

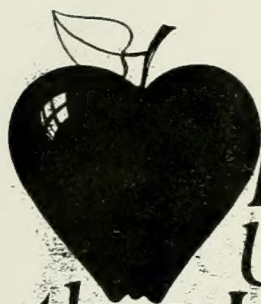
MANUAL NO. 05

ASSIGNED TO: Montana State Library

STATE DOCUMENTS COLLECTION

JUL 19 1993

MONTANA STATE LIBRARY  
1515 E. 6th AVE.  
HELENA, MONTANA 59620



Home is  
where  
the Health is

---

HOME & COMMUNITY SERVICES

MONTANA DEPARTMENT OF SOCIAL  
AND REHABILITATION SERVICES

Medicaid Services Division  
111 Sanders  
Helena, MT 59604





**Home and Community Based Services**  
**Revisions Transmittal, No. 13**  
03/01/01

Please make the following revisions to your Home and Community Based Services Manual.

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revisions dates.
299-4	Directory of Case Management Teams	Updated list.
299-5	Directory of Regional Program Officers	Updated list. (Missoula office)
411	Termination of Services	Added "Refer to HCBS 417 for exceptions to this policy." on bottom of page 2. Added "Refer to HCBS 417 for exceptions to this policy." in 1 <sup>st</sup> paragraph; revised 3 <sup>rd</sup> paragraph on page 3. Added "Refer to HCBS 417 regarding payment for other HCBS services." to top of page 4.
417	Bed-Hold Days	New section.
501	Service Requirements	Added Consumer/Family Intensive Support Service and Residential Habilitation to list.
503	Adult Day Health	Added "or licensed practical nurse" to "2." and added " <u>BED-HOLD DAYS...</u> " to bottom of page 1.
504	Adult Residential Care	Removed references to Residential Hospice from section. Revised <u>LIMITATIONS</u> on page 2. Added " <u>BED-HOLD DAYS...</u> " to page 3.
513	Environmental Accessibility Adaptations	Revised entire section.
513B	Consultant	New section.
518	Personal Assistance	Added "providing HCBS personal assistance only" to " <u>SERVICE LIMITATIONS</u> " on page 2. Added " <u>BED-HOLD DAYS...</u> " to page 3.
522	Private Duty Nursing	Added " <u>BED-HOLD DAYS...</u> " to page 2.
529	Specially Trained Attendant	Added " <u>BED-HOLD DAYS...</u> " to page 2.
532	Supported Living	Added " <u>BED-HOLD DAYS...</u> " to page 2.
599-1	HCBS Administrative Rules	Revised rules as of 9/30/00.
599-6	Nursing Facility Rates	Moved to section 699-8.
699-4	Procedure Codes and Rates	Changed Consultation rate to \$4000.00.
699-8	Medicaid Nursing Facility Reimbursement Rates	Update rates as of 12/1/00.
899-9	Adult Residential Care Calculation (DPHHS-SLTC-132) Instructions	Revised entire section and form.

**Note:** The department is in the process of revising entire manual. All references to administrative rules and forms will be updated at that time.







# Home and Community Based Services

## Revisions Transmittal, No. 10

7/1/00

Please make the following revisions to your Home and Community Based Services Manual.

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revised dates on the following sections.
299-4	Directory of Case Management Teams	Updated case managers and added e-mail addresses.
299-5	Directory of Regional Program Officers	Added Chesa Sullivan to Butte District Office.
310	Serious Occurrence Report	Renumbered section to 311. Added " <u>DISTRIBUTION</u> " to page 1. Added "other than those listed above" to 2 <sup>nd</sup> paragraph on page 2.
311	Principles of Charting	Renumbered section to 310.
410	Prior Authorization	Removed "7. Specially Trained Attendant...." from page 1
412	Referrals for Service	Changed "contact" to "referral" in last paragraph on page 1.
504	Adult Residential Care	Added "The provider may bill on date of admission...." under <u>LIMITATIONS</u> on page 2.
529	Specially Trained Attendant	Changed number of TBI-specific training hours from 16 to 10 under " <u>REQUIREMENTS</u> " on page 1.
534	Consumer/Family Intensive Support Service	New Section
699-4	Procedure Codes and Rates	Raised rates on homemaker, personal assistance, personal assistance - nurse supervision, specially trained attendant, respite, private duty nursing under 4 hours, and residential habilitation.
699-8	Medicaid Nursing Facility Reimbursement Rates	New Section
899-2	Reporting Requirements, Forms & Instructions	Revised instructions for Report 5, HCBS Utilization Report on pages 4 and 5. Revised report form on page 9.
899-3	Case Management Performance Standards	Revised "1." And added "5." on page 1.
899-5	Plan of Care Cost Limits	Added "FY01 \$22,000".
899-9	Adult Residential Care Calculation (DPHHS-MA-132) Instructions	Revised " <u>DISTRIBUTION</u> " on page 1. Added "A recipient in a "B" bed does not qualify for state supplement." on page 2 under "(A')". Added " <u>NOTE:</u> " on page 3.
899-11	Plan of Care (DPHHS-MA-135) Instructions	Revised " <u>Health Care Professional</u> " on page 6.
899-11B	Plan of Care Short Form (DPHHS-MA-135B) Instructions	Added "or short term temporary enrollment" to end of 1 <sup>st</sup> paragraph on page 1
899-12	Intake Sheet	Instructions remain the same. Form has been revised to include more options under service setting. When using older version of form, write in new options.



# Home and Community Based Services

## Revisions Transmittal, No. 10

7/1/00

Please make the following revisions to your Home and Community Based Services Manual.

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
899-20	Waiting List Criteria Tool (DPHHS-SLTC-146) Instructions	<p>Changed minimum and maximum score under "PROCEDURE" and changed "Review Dates and Scores" to "Review Dates" on page 1. Revised "14." and renumbered it to "15" and renumbered "15" to "14" on page 4. Added "Total Score" on page 5. Removed scoring from #14 on SLTC-146 and renumbered it 15. Renumbered 15 to 14 on SLTC-146 on page 6.</p> <p><b>NOTE: As HCBS forms are reordered, the names will change from "MA" to "SLTC". For example, the MA-146 will now be SLTC-146.</b></p>



## Revisions Transmittal, No. 9

Please make the following revisions to your Home and Community Based Services Manual.

[illegible]





**Home and Community Based Services**  
**Revisions Transmittal, No. 8**  
10/1/99

Please make the following revisions to your Home and Community Based Services Manual.

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revised dates on the following sections.
299-4	Directory of Case Management Teams	Updated list.
299-5	Directory of Regional Program Officers	Updated list.
302	Fair Hearings	Changed mailing address for Hearing Officer under "REQUEST FAIR HEARINGS" on page 1.
410	Prior Authorization	Removed "5. Respiratory Therapy..." on page 1. Removed respiratory therapy under "AUTHORIZATION FOR EXCESS SERVICES" on page 2.
416	Out-of-State Services	New Section.
502	Service Limitations and Exclusions	Added 2nd paragraph.
526	Respite Care	Revised last paragraph on page 2.
528	Specialized Medical Equipment and Supplies	Added "CONSULTATION" to page 3.
599-6	Nursing Facility Medicaid Per Diem Rates	New Section
603	Provider Enrollment	Revised "PROVIDER ENROLLMENT FORMS" and "PROVIDER NUMBERS" on page 1. Added "PROVIDER TRAINING" on page 2.
605	Payment Processing	Revised 1st paragraph. Added new 2nd paragraph
699-4	Procedure Codes and Rates	Changed rate for Day Habilitation on page 2.
806	Reporting Requirements	Revised "QUARTERLY REPORTS" on bottom of page 2.
808	Transfer of Recipients or Change of Recipient's Classification	Revised entire section.
812	Consumer Advisory Councils	New Section
812-1	Consumer Advisory Councils Guidelines and Recommendations	New Section
899-2	Reporting Requirements, Forms & Instructions	Added Report 6 on page 6 and 13.
899-4	HCBS Forms Requisition	Added last paragraph on page 1. Revised copy of forms requisition on page 2.
899-11	Plan of Care (DPHHS-MA-135) Instructions	Copy of revised form only. Instructions remain the same.





**Home and Community Based Services**  
**Revisions Transmittal, No. 7**  
7/1/99

Please make the following revisions to your Home and Community Based Services Manual.

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revised dates on the following sections.
299-5	Directory of Regional Program Officers	Updated Kathy Wise telephone number. Added Lalla Chadwick as the new RPO for Bozeman. Added E-mail addresses.
299-7	Summary of the Montana Medicaid Program	Updated list.
309	Reporting Recipient Abuse and Neglect	Changed "REQUIREMENT" to "DESCRIPTION" and added new "REQUIREMENT".
399-3	Tip for Caregivers: A Questionnaire	New section.
410	Prior Authorization	Changed the prior authorization limit from \$2000 to \$8000 for environmental accessibility adaptations and from \$2000 to \$5000 for specialized medical equipment or supplies.
504	Adult Residential Care	Under " <u>LIMITATIONS</u> " on page 2, changed "4. Medical Alert" to "4. Personal Emergency Response System" and removed "9. Social Transportation" and "11. RN Supervision".
506	Case Management	Added "This includes on-going...." to " <u>Assessment</u> " on page 1. Added " <u>Limitations</u> " on page 2.
513	Environmental Accessibility Adaptations	Revised entire section.
524	Registered Nurse Supervision	Revised entire section.
528	Specialized Medical Equipment and Supplies	Revised " <u>DEFINITION</u> " on page 1. Added "CONSULTATION" to page 3.
599-5	Directory of Assistive Technology Practitioners	New section.
601	Provider Eligibility	Deleted "4. Be age 18 or older; and". Renumbered "5." to "4.".
699-4	HCBS Procedure Codes & Rates	Updated rates for Z0501, Z0506, Z0510, Z0512, Z0519, Z0523, Z0526, Z0545, Z0573, Z0574, Z0576.
703	Reevaluations	Revised entire section.
799-1	Screening Determination (DPHHS-MA-61)	Copy of revised form.
899-5	Plan of Care Cost Limits	POC cost limit for FY00 is \$21,000.





# Home and Community Based Services

## Revisions Transmittal, No. 6

1/1/99

Please make the following revisions to your Home and Community Based Services Manual. ✓

SECTION NUMBER	SUBJECT	DESCRIPTION OF CHANGE
001	Contents Index	Updated revised dates on the following sections and added Service Animals section.
002	Alpha Subject Index	Added subjects.
308	Quality Assurance	New text and renamed section.
404	Care Categories	Revised number "8.", "PLAN OF CARE AMENDMENTS", AND PLAN OF CARE ANNUAL UPDATES" on page 2.
410	Prior Authorization	Deleted Dietitian and Personal Assistance Services.
413	Waiting List Criteria	Revised 2nd paragraph on page 1. Added "Waiting List Database" on pages 2.
504	Adult Residential Care	Revised 1st paragraph under "LIMITATIONS" on page 2. Revised 2nd and 3rd paragraph under "REIMBURSEMENT" on pages 2 and 3.
512	Dietitian	Removed "SERVICE LIMITATIONS".
801	Case Management Requirements	Revised "CONTRACT TERMS AND CONDITIONS" on page 2.
899-2	Reporting Requirements, Forms & Instructions	Changed "CASE MANAGEMENT EVALUATION SUMMARY" to PROVIDER PREPARED STANDARDS" under REPORT 2 on page 1. Revised "PLAN OF CARE COMPLETENESS" on page 2. Added "MANUAL" AND "STAFFING" on page 3. Added report due dates on page 5. Added "Unit Cost" and "Total" on page 5. Revised Quarterly Utilization Report to include column for unit cost. Revised Provider Prepared Standards report.
899-3	Case Management Performance Standards	Revised entire section.
899-9	Adult Residential Care Calculation Instructions	Added "Medicaid Number" and "RH - Residential Hospice" and revised paragraph "A)" under INSTRUCTIONS on page 1. Revised copy of DPHHS-MA-132.
899-11B	Plan of Care Short Form Instructions	Revised 1st paragraph under "PURPOSE".
899-22	Request for Prior Authorization	Page 1 remains the same. Copy of revised DPHHS-MA-149.
899-25	Waiting List Database Instructions	New section. This section will be updated in the near future to include all instructions on the database.
9901	Definitions	Added definition for Traumatic Brain Injury
9902	Abbreviations/Acronyms/Initials	Added acronyms.











Department of Public Health  
and Human Services

## SECTION:

INDEXES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Contents Index

TABLE OF CONTENTS

DATE ISSUED  
OR REVISED

0	<u>INDEXES</u>	
001	Contents Index	03/01/01
002	Alpha Subject Index	01/01/99
100	<u>INTRODUCTION</u>	
101	Manual Program	04/01/96
102	Clarifying/Interpreting Policy or Procedure	04/01/96
200	<u>PROGRAM DESCRIPTION</u>	
201	Program Goals	04/01/96
202	Legal Authority	04/01/96
203	Federal Requirements	07/01/97
204	Organizational Responsibilities	07/01/97
205	Medicaid Overview	04/01/96
206	Medicaid Services	10/01/97
207	Relationship of Medicaid to Home and Community Based Services Program	04/01/96
208	Relationship of Medicaid & Medicare	04/01/96
299	Appendix	
299-1	Department Organization Chart	04/01/96
299-2	Division Organization Chart	04/01/96
299-3	Flow Chart of Major Functions	07/01/97
299-4	Directory of Case Management Teams	03/01/01
299-5	Directory of Regional Program Officers	03/01/01
299-6	Directory of County Offices of Human Services	04/01/96
299-7	Summary of Montana Medicaid Program	07/01/99

## SECTION:

INDEXES

## SUBJECT:

Contents Index

300 GENERAL PROGRAM ADMINISTRATION

301	Civil Rights	04/01/96
302	Fair Hearings	10/01/99
303	Release of Information/Confidentiality	04/01/96
304	Third Party Liability	04/01/96
305	Fraud and Abuse	04/01/96
306	Surveillance & Utilization Review	04/01/96
307	Medicaid Management Information System	04/01/96
308	Monitoring & Evaluation	01/01/99
309	Reporting Recipient Abuse and Neglect	07/01/99
310	Serious Occurrence Report	07/01/00
311	Principles of Charting	07/01/00
399	Appendix	
399-1	Example of Consent Form	04/01/96
399-2	Elder Abuse Law	04/01/96
399-3	Tips for Caregivers: A Questionnaire	07/01/99

400 ELIGIBILITY FOR SERVICES

401	Medicaid Eligibility Requirements	07/01/97
402	Home & Based Community Services Eligibility Requirements	04/01/96
403	Developmentally Disabled	04/01/96
404	Care Categories	03/01/00
405	Recipient Identification	04/01/96
406	Restricted Card Program	04/01/96
407	Copayments	04/01/96
408	Freedom of Choice	04/01/96
409	Private Pay	04/01/96
410	Prior Authorization	07/01/00
411	Termination of Services	03/01/01
412	Referrals for Service	07/01/00
413	Waiting List Criteria	01/01/99
414	Medically Needy Billing Procedures	10/01/96
415	Residency Requirements	04/01/96
416	Out-of-State Services	10/01/99
417	Bed-Hold Days	03/01/01
499	Appendix	
499-1	Medicaid Identification Card	04/01/96
499-2	Restricted Card	04/01/96
499-3	Provider Inquiry of Medicaid Eligibility (SRS-MA/FA 456)	04/01/96
499-4	Provider Information Memo (SRS-FA 454)	04/01/96



## SECTION:

INDEXES

## SUBJECT:

Contents Index

500 ELIGIBLE SERVICES

501	Service Requirements	03/01/01
502	Service Limitations & Exclusions	10/01/99
503	Adult Day Health	03/01/01
504	Adult Residential Care	03/01/01
505	Behavioral Programming	04/01/96
506	Case Management	07/01/99
507	Chemical Dependency Counseling	04/01/96
508	Cognitive Rehabilitation	04/01/96
509	Community Residential Rehabilitation	04/01/96
510	Comprehensive Day Treatment	07/01/98
511	Day Habilitation	04/01/96
512	Dietitian	01/01/99
513	Environmental Accessibility Adaptations	03/01/01
513B	Consultant	03/01/01
514	Habilitation	10/01/96
515	Homemaker	10/01/96
516	Nutrition	04/01/98
517	Occupational Therapy	04/01/96
518	Personal Assistance	03/01/01
519	Personal Emergency Response System	04/01/98
520	Physical Therapy	04/01/96
521	Prevocational Training	03/01/00
522	Private Duty Nursing	03/01/01
523	Psychosocial Consultation	04/01/96
524	Registered Nurse Supervision	07/01/99
525	Respiratory Therapy	04/01/96
526	Respite Care	10/01/99
527	Special Child Care for Children with AIDS	04/01/96
528	Specialized Medical Equipment & Supplies	03/01/00
529	Specially Trained Attendants	03/01/01
530	Speech Therapy and Audiology	04/01/96
531	Supported Employment	04/01/98
532	Supported Living	03/01/01
533	Transportation	04/01/96
534	Consumer/Family Intensive Support Service	07/01/00
599	Appendix	
599-1	Home & Community Services	
	ARM 37.40.1401 - 37.40.1488	03/01/01
599-2	Proposal Form Sample	04/01/96
599-3	Service Animals - Case	07/01/98
	Management Team's Role	
599-4	Service Animals - Consumer's	07/01/98
	Role	

## SECTION:

INDEXES

## SUBJECT:

Contents Index

500 ELIGIBLE SERVICES

599-5	Directory of Assistive Technology Practitioners	07/01/99
599-6	Reserved	03/01/01
599-7	Consumer Recycling Agreement	03/01/00

600 PROVISION OF SERVICES

601	Provider Eligibility	07/01/99
602	Provider Responsibilities	04/01/96
603	Provider Enrollment	10/01/99
604	Payment Requirements	04/01/96
605	Payment Processing	10/01/99
606	Reimbursement Methodology	04/01/96
607	Licensure Requirements	10/01/96
699	Appendix	
699-1	Provider Requirements, (ARM 46.12.301-308)	01/01/98
699-2	Provider Enrollment Form	07/01/97
699-3	HCFA 1500 Claim Form	04/01/96
699-4	HCBS Procedure Codes & Rates	03/01/01
699-5	HCBS Provider Update Form	07/01/97
699-6	HCBS Prior Authorization Form	04/01/98
699-7	HCBS Prior Authorization Change Request Form	01/01/98
699-8	Medicaid Nursing Facility Reimbursement Rates	03/01/01

700 PREADMISSION SCREENING

701	Screening Requirements	07/01/97
702	Screening Referral Procedures	07/01/97
703	Reevaluations	07/01/99
799	Appendix	
799-1	Screening Determination - Form DPHHS-MA 61	07/01/99



## SECTION:

INDEXES

## SUBJECT:

Contents Index

800 CASE MANAGEMENT SYSTEM

801	Case Management Requirements	01/01/99
802	Case Management Team Requirements	04/01/96
803	Service Areas	01/01/98
804	Record Requirements	04/01/96
805	Reserved	
806	Reporting Requirements	10/01/99
807	Contract Termination & Transition	04/01/96
808	Transfer of Recipients or Change of Recipient's Classification	10/01/99
809-1	Plan of Care: Development	04/01/96
809-2	Plan of Care: Components	04/01/96
809-3	Plan of Care: Requirements	07/01/97
809-4	Plan of Care: Costs	04/01/96
809-5	Plan of Care: Reevaluations	07/01/97
809-6	Plan of Care: Amendments	04/01/96
809-7	Plan of Care: Annual Updates	07/01/97
810	Discretionary Funds	04/01/98
811	Year-End Money	04/01/98
812	Consumer Advisory Councils	10/01/99
812-1	Consumer Advisory Councils Guidelines and Recommendations	10/01/99
899	Appendix	
899-1	Vacant	10/01/96
899-2	Reporting Requirements, Forms & Instructions	07/01/00
899-3	Performance Standards	07/01/00
899-4	HCBS Forms Requisition	10/01/99
899-5	Plan of Care Cost Limits	07/01/00
899-6	Entrance Into Medicaid & HCBS (DPHHS-MA-55) Instructions	04/01/96
899-7	Request for Modified Screen/MA-61 Issuance (DPHHS-MA-63) Instructions	07/01/97
899-8	Level of Care Determination (DPHHS-MA-86) Instructions	07/01/97
899-9	Adult Residential Care Calculation (DPHHS-MA-132) Instructions	03/01/01
899-10	Plan of Care Cost Sheet (DPHHS-MA-134) Instructions	07/01/97
899-11	Plan of Care (DPHHS-MA-135) Instructions	07/01/00
899-11B	Plan of Care Short Form (DPHHS-MA-135B) Instructions	07/01/00

## SECTION:

INDEXES

## SUBJECT:

Contents Index

800 CASE MANAGEMENT SYSTEM

899-12	Intake Sheet (DPHHS-MA-136)	
	Instructions	07/01/00
899-13	Discharge Sheet (DPHHS-MA-137)	
	Instructions	07/01/97
899-14	Personal Assistance Services HCBS	
	Referral/Amendment Form	
	(DPHHS-MA-138) Instructions	01/01/97
899-15	Reevaluation Form (DPHHS-MA-139)	
	Instructions	04/01/96
899-16	Amendment Form (DPHHS-MA-141)	
	Instructions	04/01/96
899-17	Psychosocial Summary	
	(DPHHS-MA-143) Instructions	04/01/96
899-18	Letter of Notification	
	(DPHHS-MA-144) Instructions	04/01/96
899-19	Level I Screen (DPHHS-MA-145)	
	Instructions	07/01/97
899-20	Waiting List Criteria Tool	
	(DPHHS-SLTC-146) Instructions	07/01/00
899-21	Request for Prior Authorization	
	CC3 (DPHHS-MA-148) Instructions	04/01/96
899-22	Request for Prior Authorization	
	(DPHHS-MA-149) Instructions	01/01/99
899-23	Service Animals - Provider	
	Assurances (DPHHS-MA-142)	07/01/98
	Instructions	
899-24	Service Animals - Stewardship	
	Agreement (DPHHS-MA-142)	07/01/98
	Instructions	
899-25	Waiting List Database	
	Instructions	01/01/99

9900 APPENDIX

9901	Definitions	01/01/99
9902	Abbreviations/Acronyms/Initials	01/01/99

o o o



Department of Social and Rehabilitation Services	SECTION:  INDEXES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Alpha Subject Index

	<u>SUBJECT</u>	<u>HCBS NUMBER</u>
<u>A</u>	Abbreviations/Acronyms/Initials	9902
	Administrative Rule of Montana, HCBS	599-1
	Administrative Separateness	801
	Adult Day Health Services	503
	Adult Foster Homes	504
	Adult Residential Care Services	504
	Adult Residential Care Calculation Form	899-9
	Amendment Form	899-16
<u>B</u>	Behavioral Programming Services	505
<u>C</u>	Care Categories	404
	Care Category 3 (CC3) Request for	
	Prior Authorization Form	899-21
	Case Management Services	506
	Case Management, Performance Standards	899-3
	Case Management, Requirements	801
	Case Management Teams, Directory	299-4
	Case Management Team Requirements	802
	Charting, Principles of	310
	Chemical Dependency Counseling Services	507
	Choice, Individual	408
	Civil Rights	301
	Clarifying/Interpreting Policy or Procedure	102
	Cognitive Rehabilitation Services	508
	Community Residential Rehabilitation	509
	Compliance Reviews	308
	Comprehensive Day Treatment Services	510
	Confidentiality	303
	Consent Form	399-1
	Contents Index	001
	Contract Termination and Transition	807
	Contract Terms and Conditions	801
	Copayments	407
	County Office of Human Services,	
	Directory	299-6

## SECTION:

INDEXES

## SUBJECT:

Alpha Subject Index

<u>D</u>	DPHHS Manual Program	101
	Day Habilitation Services	511
	Deeming, Waiver of	401
	Definitions	9901
	Department Organization Chart	299-1
	Deprivation Codes	405
	Developmentally Disabled	403
	Dietitian Services	512
	Discharge Date	411
	Discharge Sheet	899-13
	Discretionary Funds	810
	Division Organization Chart	299-2
<u>E</u>	Elder Abuse Law	399-2
	Enrollment Limits	801
	Entrance Into Medicaid & HCBS Form	899-6
	Environmental Accessibility Adaptations	513
	Explanation of Medicaid Benefits (EOMB)	306
<u>F</u>	Fair Hearings	302
	Federal Requirements	203
	Flow Chart of Major Functions	299-3
	Fraud and Abuse	305
	Freedom of Choice	408
	Funding, Program	203
<u>G</u>	Goals, Program	201
	Group Home Services	504
<u>H</u>	Habilitation Services	511 & 514
	HCFA 1500 Claim Form	699-3
	Home & Community Based Services ARM	599-1
	Home & Community Based Services Eligibility Requirements	402
	Homemaker Services	515
	Hospitalization	411
<u>I</u>	Intake Sheet	899-12
	Intensive Institutional Care (Heavy Care)	404



SECTION:	SUBJECT:
INDEXES	Alpha Subject Index

<u>L</u>	Legal Authority	202
	Letter of Notification	899-18
	Level of Care Screenings	701
	Licensure Requirements	607
	Letter of Notification Form	899-18
	Level of Care Determination Form	899-8
	Level I Screen Form	899-19
<u>M</u>	Manual Program	101
	Medicaid Eligibility Requirements	401
	Medicaid Identification Card	499-1
	Medicaid Management Information System	307
	Medicaid Overview	205
	Medicaid Services	206
	Medically Needy Billing Procedures	414
	Medicare, Relationship to Medicaid	208
	Montana Medicaid Program, Summary	299-7
<u>N</u>	Nutrition Services	516
<u>O</u>	Occupational Therapy Services	517
	Organization Chart, Department	299-1
	Organization Chart, Division	299-2
	Organizational Responsibilities	204
	Over Cost Plan of Cares and Services	410
<u>P</u>	Payment Processing	605
	Payment Requirements	604
	Performance Standards, Case Management	899-3
	Personal Assistance Services	518
	Personal Assistance, Referral Procedures	899-14
	Personal Care Facilities	504
	Personal Emergency Response System	519
	Physical Therapy Services	520
	Plan of Care, Amendments	809-6
	Plan of Care, Amendment Form	899-16
	Plan of Care, Annual Updates	809-7
	Plan of Care, Components	809-2
	Plan of Care, Cost Sheet	899-10
	Plan of Care, Development	809-1
	Plan of Care Cost Limits	899-5
	Plan of Care Limits, Summary	809
	Plan of Care, Form	899-11
	Plan of Care Short Form	899-11B

## SECTION:

## INDEXES

## SUBJECT:

## Alpha Subject Index

<u>P</u>	Plan of Care, Reevaluation Form	899-15
	Prevocational Training Services	521
	Principles of Charting	310
	Prior Authorization	410
	Prior Authorization Request Form	899-22
	Private Duty Nursing Services	522
	Private Pay	409
	Procedure Codes & Rates	699-4
	Procurement Process	801
	Program Goals	201
	Proposal Form for Environmental Accessibility Adaptations	599-2
	Provider Eligibility	601
	Provider Enrollment	603
	Provider Enrollment Form	699-2
	Provider Information Memo (DPHHS-FA 454)	499-4
	Provider Inquiry of Medicaid Eligibility (SRS-MA/FA 456)	499-3
	Provider Requirements ARM	699-1
	Provider Responsibilities	602
	Provider Update Form	699-5
	Psychosocial Consultation Services	523
	Psychosocial Summary Form	899-17
<u>Q</u>	Quarterly Reports	899-2
	Quaility Assurance	308
<u>R</u>	Rates	699-4
	Recipient Abuse and Neglect Reporting	309
	Recipient Identification	405
	Record Requirements	804
	Re-enrollment	411
	Reevaluations, Screening	703
	Reevaluation Form	899-15
	Referrals for Service	412
	Registered Nurse Supervision Services	524
	Regional Program Officers, Directory	299-5
	Reimbursement Methodology	606
	Relationship of Medicaid to Home & Community Services Program	207
	Relationship of Medicaid & Medicare	208
	Release of Information/Confidentiality	303
	Reporting Requirements	806
	Reporting Requirements, Forms & Instructions	899-2
	Request for Modified Screen/MA-61 Issuance	899-7
	Request for Prior Authorization CC3 Form	899-21



## SECTION:

INDEXES

## SUBJECT:

Alpha Subject Index

<u>R</u>	Request for Prior Authorization Form	899-22
	Residency Requirements	415
	Respiratory Therapy Services	525
	Respite Care Services	526
	Respite, Authorization of Excess	410
	Restricted Card, Example	499-2
	Restricted Card Program	406
<u>S</u>	Screening Determination Form (Form DPHHS-MA-61)	799-2
	Screening Referral Procedures	702
	Screening Requirements	701
	Senior and Long Term Care Division Organization Chart	299-2
	Service Areas	803
	Service Limitations & Exclusions	502
	Service Requirements	501
	Special Child Care for Children with AIDS	527
	Specialized Medical Equipment & Supplies	528
	Specially trained Attendants	529
	Speech Therapy & Audiology Services	530
	State Plan	205
	Supported Employment Services	531
	Supported Living Services	532
	Surveillance & Utilization Review	306
<u>T</u>	Termination of Service	411
	Third Party Liability	304
	Traumatic Brain Injury Definition	9901
	Transfer of Assets	401
	Transfer of Recipients or Change of Recipient's Classification	808
	Transportation Services	533
<u>W</u>	Waiting List Criteria	413
	Waiting List Criteria Tool	899-20
	Waiting List Database Instructions	899-25
	WM Modifier	811
<u>Y</u>	Year-End Money	811

o o o





Department of Public Health and Human Services	SECTION:  INTRODUCTION
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Manual Program

OBJECTIVE: This manual provides policies, procedures, data, information and instructions covering the Home and Community Based Services Program. This manual replaces all previously issued policy and procedural information relating to the Home and Community Based Services Program.

MANUAL REVISIONS: Changes to program policy are transmitted by manual page revisions. Manual revisions are completed by the manual originator on a quarterly basis (January, April, July and October). Critical information will be transmitted immediately.

Manual pages contain information of value for long-term retention and are formally prepared, edited, identified, filed and indexed. Upon receipt, remove the obsolete manual pages and place the new and revised pages in your manual.

CONTROL NUMBER--The control number for each manual page is the HCBS number. For accurate placement, file all documents in numerical sequence (from FRONT to REAR) in the appropriate manual chapter.

MANUAL MAINTENANCE: MANUAL HOLDER'S RESPONSIBILITY--The manual holder is responsible for inserting documents and keeping the manual up-to-date. The Contents Index indicates the publication date of each subject listed to assist in auditing the contents of the manual.

Missing or Superseded Documents--Send requests to the Manual Originator.

## SECTION:

INTRODUCTION

## SUBJECT:

Manual Program

## INFORMATION

## RETRIEVAL:

CONTENTS INDEX--This index lists the subjects by number.

Contents Check--To determine if a particular document is the latest one published, check the date of page 1 of the document against the publication date listed in the Contents Index. At least once a year, check all documents to be certain that the manual is complete and up-to-date.

ALPHA SUBJECT INDEX--This index lists the subjects alphabetically.

REVISION PERIODS--Indexes are updated quarterly to cover all changes, to include all new documents being added, and to remove obsolete data, documents, or forms.

o o o

Department of Public Health  
and Human Services

**SECTION:**

INTRODUCTION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Clarifying/Interpreting  
Policy or Procedure

If, after consulting this manual, individuals are unable to answer questions or resolve issues that arise in the course of their work, a clarification or interpretation of policy may be requested from the Regional Program Officer.

o o o





Department of Public Health  
and Human Services

## SECTION:

PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Program Goals

PROGRAM GOALS--The goal of the Home and Community Based Services Program is to promote the health and independence of Medicaid recipients who require long-term care. The program also contains health care costs by providing home-based services.

The program accomplishes these goals by:

1. Providing persons a choice of home or institution to meet their long-term care needs;
2. Offering persons a less restrictive alternative;
3. Enhancing the use of natural support systems, such as family and volunteers;
4. Eliminating duplication of services through effective case management; and
5. Ensuring that persons participate in developing their own plans of care.

o o o





Department of Public Health and Human Services	SECTION:  PROGRAM DESCRIPTION
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Legal Authority

LEGAL AUTHORITY--Section 2176 of Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, added Section 1915(c) to the Social Security Act. This section authorized the Secretary of Health and Human Services to waive certain Medicaid statutory limitations in order to allow states to cover Home and Community Based Services that individuals may need to avoid institutionalization. States with approved waivers can be reimbursed for Home and Community Based Services to individuals who would otherwise require the level of care provided in a nursing facility.

Federal regulations governing the Home and Community Based Services Program are in 42 CFR 441.300 through 441.310.

Section 53-6-401 and 53-6-402 of the Montana Codes Annotated and Section 46.12.1401 through 46.12.1482 of the Administrative Rules of Montana (ARM) provide the state legal authority to implement the Home and Community Based Services Program. (Refer to Appendix 599-1 for a copy of the Home and Community Based Services ARM.)

o o o



Department of Public Health  
and Human Services

## SECTION:

PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Federal Requirements

REFERENCE: 42 CFR 441.300-310

GENERAL PROGRAM  
DESCRIPTION:

FEDERAL REQUIREMENTS--The Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA), monitors the implementation of all Home and Community Based Service (HCBS) waivers to determine if federal requirements are being met.

To be granted a waiver, states are required to:

- Establish necessary safeguards to protect the health and welfare of individuals receiving services under HCBS. This includes establishing and enforcing safety and related standards for board and care facilities covered by Section 1616(e) of the Social Security Act (commonly known as the Keys Amendment). This amendment covers institutions, foster homes, or group living arrangements where a significant number of SSI recipients are residing or are likely to reside;
- Establish procedures for assessing the need for services for all program applicants;
- Assure that all persons determined eligible for the program are informed of their choice of home and community or institutional care as well as their choice of service providers;
- Demonstrate that average per capita costs for long-term care under HCBS will not exceed reasonable estimates of average per capita costs incurred if the waiver were not granted;



## SECTION:

PROGRAM DESCRIPTION

## SUBJECT:

Federal Requirements

- Assure financial accountability for funds expended under the waiver;
- Comply with a data collection plan on the impact of the waiver.

EFFECTIVE DATE--Effective dates for waivers are established by HCFA. Waivers may be granted for a three year period or renewed for five year periods. Montana's current waiver is in effect until June 30, 2001.

PROGRAM FUNDING: To receive federal funds for the program, states must follow federal regulations. The waiver program is financed jointly by the state and federal government. The federal matching rate is based on a state's annual average per capita income. This rate varies, and currently, approximately 71 percent of the funding is federal and 29 percent is state.

o o o

Department of Public Health  
and Human Services

## SECTION:

## PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Organizational Responsibilities

ORGANIZATIONAL RESPONSIBILITIES--The Home and Community Based Services (HCBS) Program has multiple levels of program involvement. The responsibilities of the organizations follow.

FEDERAL: The U.S. Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA) is the agency responsible for administering the Medicaid Program at the federal level.

STATE: The Department of Public Health and Human Services is the single state agency responsible for administering the Medicaid Program at the state level. (Refer to Appendix 299-1 of this chapter for the Department Organizational Chart.)

DIVISION: The Senior and Long Term Care Division is responsible for developing, implementing and monitoring policies and procedures for all senior and long term care services, including the Medicaid Home and Community Based Services Program. (Refer to Appendix 299-2 for the Division Organizational Chart.)

REGIONAL PROGRAM  
OFFICERS:

Regional Program Officers (RPOs) are Department employees who are supervised by the Community Services Bureau of the Division. They are located in DPHHS District Offices or County Offices of Human Services around the state. The RPOs are primarily responsible for local representation of the Community Services Bureau programs, which include preadmission screening, personal assistance, HCBS, hospice, dialysis attendant, and home health agency services. (Refer to Appendix 299-5 for a directory of Regional Program Officers.)

**SECTION:**

PROGRAM DESCRIPTION

**SUBJECT:**

Organizational Responsibilities

**MOUNTAIN PACIFIC  
QUALITY HEALTH  
FOUNDATION:**

The Mountain Pacific Quality Health Foundation is a peer review organization which contracts with the Department to perform Level I and preadmission screening for long term care services, including annual review of level of care for HCBS recipients.

**CASE MANAGEMENT  
TEAMS:**

The Department contracts with Case Management Teams (CMT) to serve a designated number of individuals who are elderly or have a disability. The CMT serves specified counties. The CMT develops and monitors individual plans of care. After the plan is approved, the CMT contacts agencies in the community to provide the necessary services and monitors the services to ensure they continue to meet the recipient's needs. (Refer to Appendix 299-4 of this chapter for a directory of the Case Management Teams and their counties of coverage.)

**ELIGIBILITY  
STAFF:**

Eligibility Staff are Department employees located in County Offices of Human Services who determine financial eligibility for Medicaid. (Refer to Appendix 299-6 for a directory of county offices.)

**FISCAL AGENT:**

The Department currently contracts with Consultec, Inc. to process all Medicaid claims.

**FLOW CHART OF  
MAJOR FUNCTIONS:**

Refer to Appendix 299-3 of this chapter to identify the major functional activities of the Home and Community Based Services Program.

o o o



Department of Public Health  
and Human Services

**SECTION:**

PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Medicaid Overview

MEDICAID OVERVIEW--The purpose of the Medicaid Program is to provide categorically eligible and medically needy persons with ongoing and preventive medical care necessary for maintaining their health and promoting their own self-care. The Medicaid Program was created in 1965, by Congress through Title XIX of the Social Security Act and was implemented in Montana in 1967, through Title 53 Chapter 6 of the Montana Codes Annotated and Section 46.12 of the Administrative Rules of Montana. The Montana Department of Public Health and Human Services is the designated single state agency for purposes of administering the Medicaid Program.

FEDERAL REQUIREMENTS--In order to receive federal funds for the program, the state must follow the federal regulations in 42 CFR, Part 430 to 460. The regulations provide for two types of Medicaid Programs: mandatory and optional. Mandatory programs must be offered for states to receive federal Medicaid funds. Federal Medicaid funds are available for optional programs if state legislatures authorize the expenditure of state funds.

STATE PLAN--States define the extent and scope of services provided, service standards and rates of payment to providers. These details are provided to HCFA in a State Plan which can be amended at any time. Services available to all Medicaid recipients are called State Plan services.

o o o



Department of Public Health  
and Human Services

## SECTION:

## PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Medicaid Services

Reference: 42 CFR 440.210 and 440.220

MANDATORY SERVICES--Medicaid services required by the federal government include the following:

- Inpatient Hospital
- Outpatient Hospital
- Physician
- Nurse Midwife
- Nurse Practitioner
- Laboratory and X-ray
- Nursing Facility Care
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under age 21.
- Family Planning
- Home Health (for individuals age 21 and over)
- Rural Health Clinics (including Federally Qualified Health Centers)

OPTIONAL SERVICES--Medicaid services that Montana has chosen to provide include the following:

- Ambulatory Surgical Centers
- Prescribed Drugs
- Intermediate Care for the Mentally Retarded (ICF/MR)
- Dental and Denturist Services



## SECTION:

PROGRAM PROCEDURES

## SUBJECT:

Medicaid Services

- Audiology/Hearing Aids
- Durable Medical Equipment, Prosthetic Devices, Medical Supplies
- Eyeglasses and Optometric Services
- Community Mental Health
- Speech, Occupational and Physical Therapy
- Personal Assistance
- Home Dialysis Attendant Care
- Podiatry
- Psychology
- Social Work
- Licensed Professional Counselors
- Nurse Specialist
- Hospice
- Diagnostic Clinics
- Freestanding Dialysis Clinics
- Targeted Case Management
- Transportation Services

PROGRAM LIMITATIONS--States have the option to establish limitations on the amount of services available to Medicaid recipients.

Refer to Appendix 299-7 of this section for a summary of Montana's Medicaid services. The summary outlines program scope, limitations, reimbursement and copayment requirements for all covered services.

o o o

Department of Public Health  
and Human Services

**SECTION:****PROGRAM DESCRIPTION**

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Relationship of Medicaid to  
the Home and Community Based  
Services Program

GENERAL RULE--The Home and Community Based Services (HCBS) Program is referred to as the "Medicaid Waiver" Program because the federal government waived certain Medicaid statutory requirements to allow the state to provide a broad array of home and community based services as an alternative to institutional care. The state can determine the home and community based services provided under the waiver, but they must be approved by HCFA as cost-effective and necessary to prevent institutionalization.

WAIVERS APPLIED--The requirements of the Medicaid Program that have been waived to provide home and community based services are:

- Traditional Service Definition - Services provided under a waiver can be similar to those provided under the State Plan; however, they are either defined differently under the waiver or they differ in amount, duration or scope from services provided under the State Plan.
- Comparability of Services - Under the State Plan Medicaid Program, available services must be equal in amount, duration and scope for all recipients. This requirement was waived because our Home and Community Based Services Program serves a limited group of eligibles.

HOME AND COMMUNITY BASED SERVICES AND MEDICAID SERVICES--Recipients eligible for Home and Community Based Services remain eligible for State Plan Medicaid Program benefits. Medicaid Program benefits must be considered medically necessary to qualify for Medicaid reimbursement.

o o o





Department of Public Health  
and Human Services

SECTION:

PROGRAM DESCRIPTION

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Relationship of Medicaid and  
Medicare

DESCRIPTION OF MEDICARE--Medicare is a federal health insurance program for persons 65 years of age and older, and certain persons under the age of 65 who are disabled or who have End Stage Renal Disease. Unlike Medicaid, persons do not have to meet an income test to qualify for Medicare. Eligibility is based on the individual's work history under the Social Security or Railroad Retirement System.

PROGRAM ADMINISTRATION--Medicare, like Medicaid, is a federal government program administered by the Health Care Financing Administration (HCFA). Medicare is financed from Social Security taxes and monthly premiums and covers the same services and supplies nationwide.

HOSPITAL INSURANCE (PART A)--Medicare hospital insurance helps pay for medically necessary inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care.

MEDICAL INSURANCE (PART B)--Medicare medical insurance helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services and a number of other medical services and supplies that are not covered by hospital insurance. Medical insurance can also help pay for necessary home health services when hospital insurance cannot pay.

DEDUCTIBLES AND CO-INSURANCE--Medicare does not pay the full cost of some covered services. As with most private health insurance policies, Medicare has deductibles and co-insurance which must be paid by the insured person. If the Medicare insured person is also receiving Medicaid, the Medicaid program

## SECTION:

PROGRAM DESCRIPTION

## SUBJECT:

Relationship of Medicaid and Medicare

pays some of the deductible and co-insurance costs. Medicaid also pays the person's medical insurance premium.

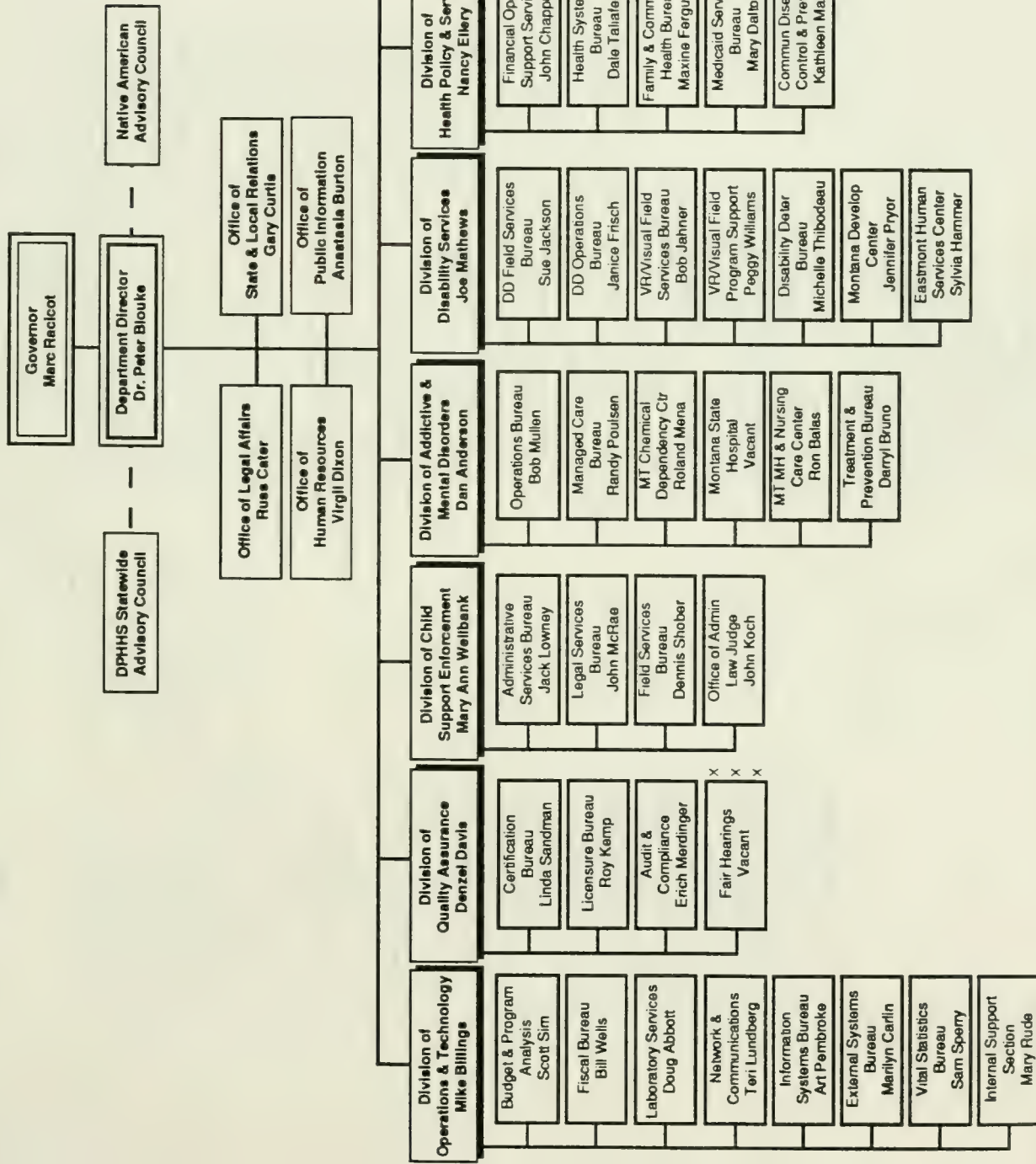
PAYMENT SYSTEM--Medicare payments are handled by private insurance organizations under contract with the federal government. Organizations handling Part A claims are called intermediaries and organizations handling Part B claims are called carriers.

In Montana, the intermediary and carrier is Blue Cross/Blue Shield. Medicare pays providers and sometimes pays the recipient. Medicare's basis for how the payments will be made is called "assignment". "Assignment" means that the provider bills and receives the payment. "Non-Assignment" means that the recipient bills and receives the payment. This principle does not apply in Medicaid since Medicaid payment is made only to providers.

FURTHER INFORMATION--For more detailed information about the Medicare Program, Blue Cross/Blue Shield should be contacted.

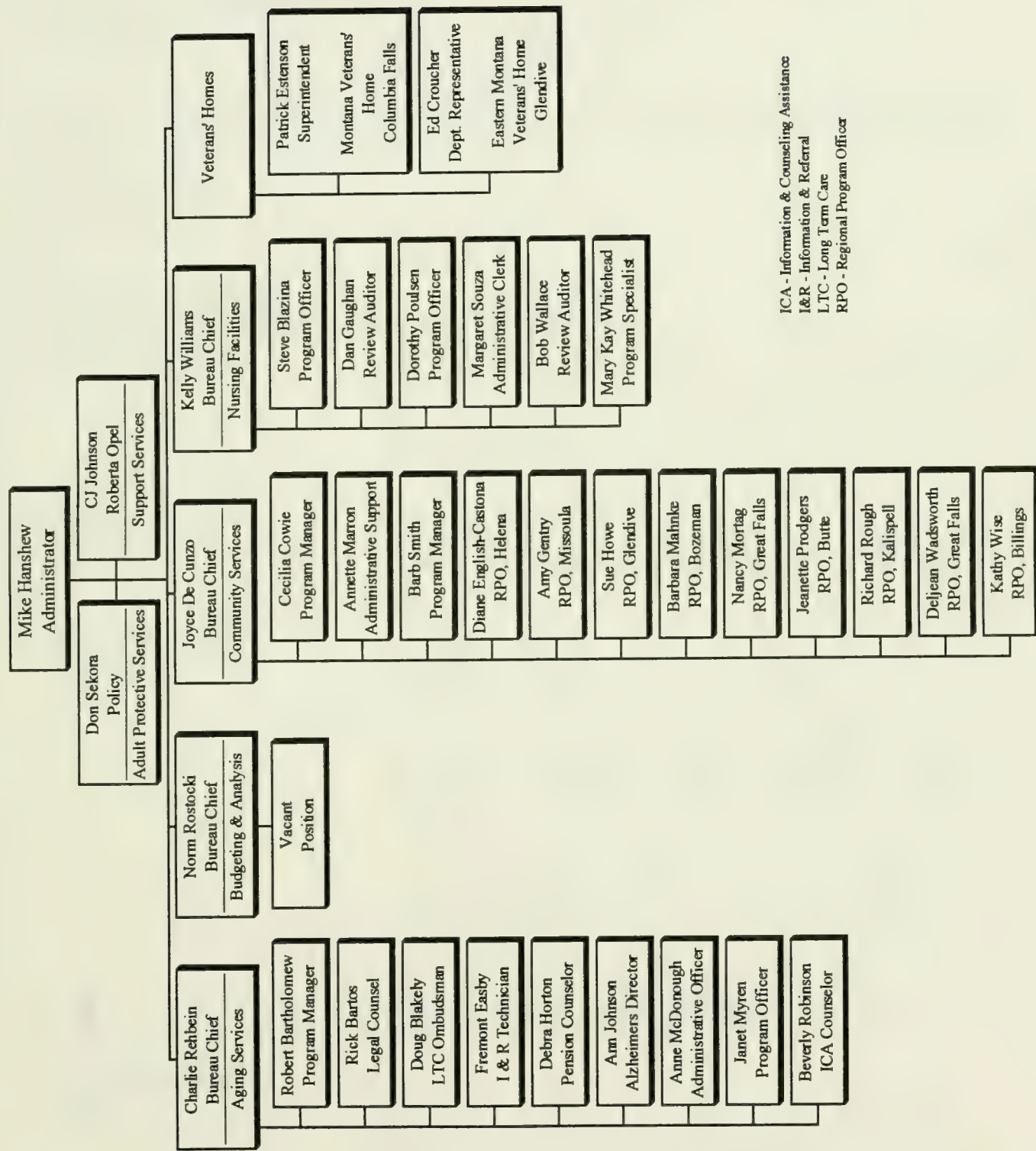
o o o

# STATE OF MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES









ICA - Information & Counseling Assistance  
 I&R - Information & Referral  
 LTC - Long Term Care  
 RPO - Regional Program Officer



Department of Public Health  
and Human Services

**SECTION:**

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Flow Chart of Major Functions

**PROCEDURE:****RESPONSIBILITY****ACTION**

Individual, Family  
and Health Care  
Professional

1. Considers institutional care or other long-term care.
2. Contacts Case Management Team, Mountain Pacific Quality Health Foundation or Eligibility Staff.

Eligibility  
Staff

3. Determines the individual's financial eligibility for Medicaid.

Mountain Pacific  
Quality Health  
Foundation

4. Screens individual to determine level of care and conducts Level I screen.
5. If individual meets institutional level of care, informs individual of the choice between Home and Community Based Services and institutional services, if feasible.
6. If individual chooses Home and Community Based Services, refers the individual to Case Management Team.
7. Case Management Team contacts individual within three working days of date of receipt of formal referral.

Case Management  
Team

8. Develops a Plan of Care with the individual, family and health care professional. The plan specifies all services to be provided and the total cost.



## SECTION:

APPENDIX

## SUBJECT:

Flow Chart of Major Functions

9. Submits Plan of Care to attending health care professional for approval and signature.
10. Arranges for services prescribed in the Plan of Care through formal and informal support systems.
11. Prior authorizes all HCBS services.
12. Monitors service providers for quality of care.
13. Provides on-going case management to individual.

Regional Program  
Officers:

Perform on-site compliance reviews and monitoring of CMTs. Responsible for prior authorizations for provision of excess services. Provide local support to CMTs.

o o o

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Directory of Case Management  
Teams

<u>NAME &amp; ADDRESS</u>	<u>STAFF</u>	<u>COUNTIES</u>
Community Hospital 607 SW Higgins Missoula, MT 59803 Phone: 327-4585 Fax: 327-4484 E-mail: lux@montana.com	Jayne Lux, RN Joann Haven, RN Laura Sherry, RN Sue Kirchmyer, RN Kathy Flynn, SW Tim Laskowski, SW Tamara Bradley, SW	Mineral, Missoula, Ravalli
Partners in Home Care 500 N Higgins, Ste 201 Missoula, MT 59801 Phone: 728-8848 Fax: 327-3688 E-mail: fabeyb@partnersinhome care.com	Marlene Swisher, RN Ruth Cleveland, SW Susan Smith, SW	Mineral, Missoula, Ravalli
Yellowstone City-County Health Dept P.O. Box 35033 Billings, MT 59107 Phone: 247-3226 Fax: 247-3202 E-mail: ronm@ycchd.org	Ron McKenna, SW Tris Newell, RN Linda Collins, RN Dee Dee Chiesa, SW Jill Egan, SW Kaye Blair, RN	Big Horn, Carbon, Rosebud, Stillwater, Sweetgrass, Treasure, Yellowstone
Easter Seal 4400 Central Ave Great Falls, MT 59405 Phone: 761-3680 Fax: 761-5110 E-mail: karlae@esgw.org	Karla Egan, LPN Tari Barkley, SW Mickie Anderson, RN Kathy Smith, RN Stu Lekander, SEAS Ruby Howington, SW	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole
District IX HRDC 321 E. Main, Ste 300 Bozeman, MT 59715 Phone: 586-3134 Fax: 585-3538 E-Mail: kayers@hrdc9.org	Rosemary Taylor, SW Sherry Mulligan, RN Charlene Findlay, SW	Gallatin, Park, Madison, Meagher

## SECTION:

APPENDIX

## SUBJECT:

Directory of Case Management  
Teams

<u>NAME &amp; ADDRESS</u>	<u>STAFF</u>	<u>COUNTIES</u>
L&C City-Co Health Dept 1930 9th Ave, Ste 207 Helena, MT 59601 Phone: 443-2584 Fax: 457-8990 E-mail: underhil@co.lewis-clark.mt.us	Jeanne Underhill, RN Kristi Heilman, RN Dana Gibson, SW Trace O'Connell, SW	Broadwater, Jefferson, Lewis and Clark
Holy Rosary Home Care 2600 Wilson St. #30 Miles City, MT 59301 Phone: 233-3810 Fax: 233-7134 E-mail: bev.askin@hr-hc.org	Sandy Short, SW Bev Askin, RN	Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Wibaux
Sidney Health Center 216 14 Ave SW Sidney, MT 59270 Phone: 488-2140 Fax: 488-5514 E-mail: hcbs@sidneyhealth.com	Robin Knaff-Bender, RN Kerry Reitz, SW Saralou O'Brien, RN	Daniels, Dawson, McCone, Richland, Roosevelt, Sheridan, Valley
NW MT Human Resources P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582 E-mail: dreimnit@kalhrdc.hhs.state.mt.us	Debbie Reimnitz, RN Sue Pratt, SW Marla Elliott, RN Emilianne Lansdown, SW	Flathead, Lake, Lincoln, Sanders
Spectrum Medical, Inc. 523 E. Front St., Ste 529 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120 E-mail: spectrum@montana.com	Kevin Skocilich, SW Georgia Peterson, RN Virginia Mick, RN Staci Berceir, SW	Beaverhead, Deer Lodge, Granite, Powell, Silver Bow
Central Montana Hospital 408 Wendell Ave Lewistown, MT 59457 Phone: 538-6297 (Kathy) 538-6382 (Cindy) Fax: 538-6267 E-mail: khodgeson@cmmc-snc.com	Kathy Hodgeson, RN Tara Taylor, SW	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Phillips Wheatland

## SECTION:

APPENDIX

## SUBJECT:

Directory of Case Management  
Teams

<u>NAME &amp; ADDRESS</u>	<u>STAFF</u>	<u>COUNTIES</u>
Area II Agency on Aging 1504 Fourth St W Roundup, MT 59072 Phone: 323-1320 Fax: 323-3859 E-mail: team@middrivers.com	Betty Jo Hiermeier, SW Stephanie Councill, RN	Carbon, Fergus, Golden Valley, Judith Basin, Mussellshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone
Western Montana AAA 110 Main St Ste 5 Polson, MT 59860 Phone: 883-7284 Fax: 883-7363 E-mail: area6cmt@cyberport. net	John Freemole, SW Karen O'Donnell, RN	Lake, Lincoln, Mineral, Ravalli, Sanders
Area VIII Agency on Aging 501 Bay Drive Great Falls, MT 59404 Phone: 454-6990 Fax: 454-6991 E-mail: toomanylbs@worldnet. att.net	Nancy Swenson, SW Mary Peterschick, RN	Cascade
Area X Agency on Aging 2 W 2nd St Havre, MT 59501 Phone: 265-5464 Fax: 265-3611 E-mail: hcca@hi-line.net	Connie LaSalle, RN Tina Thomas, SW	Hill
Area XI Agency on Aging 227 West Front Missoula, MT 59802 Phone: 728-7682 Fax: 728-7687 E-mail: senior@bigsky.net	Elizabeth Yahner, SW  John Freemole, SW Karen O'Donnell, RN Phone: 883-7284	Missoula
Area IV Agency on Aging 201 S Main P.O. Box 1717 Helena, MT 59624 Phone: 447-1680 Fax: 447-1629 E-mail: lsimmons@rmdc.mt.net	Linda Simmons, SW Ruth Sasser, RN	Broadwater, Gallatin, Jefferson, Lewis & Clark, Meagher, Park

o o o





Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Directory of Regional Program  
Officers

REGIONAL PROGRAM  
OFFICERS

COUNTIES OF COVERAGE

Kathy Wise  
DPHHS District Office  
1211 Grand Avenue  
Billings, MT 59102  
Phone: 247-2650  
Fax: 245-9437  
E-mail: kwise@state.mt.us

Yellowstone, Carbon,  
Wheatland, Musselshell,  
Big Horn, Golden Valley,  
Treasure, Stillwater

Lalla Chadwick  
DPHHS District Office  
202 South Black  
Bozeman, MT 59715  
Phone: 586-4089  
Fax: 587-7863  
E-mail: lchadwick@state.mt.us

Gallatin, Madison, Park,  
Sweetgrass

Chesa Sullivan  
DPHHS District Office  
700 Casey  
Butte, MT 59701  
Phone: 496-4989  
Fax: 782-8728  
E-mail: csullivan@state.mt.us

Beaverhead, Deer Lodge  
Granite, Silver Bow

Susan Howe  
DPHHS District Office  
218 W Bell, Ste 205  
Glendive, MT 59330  
Phone: 377-6252  
Fax: 365-6927  
E-mail: showe@state.mt.us

Carter, Custer, Daniels,  
Dawson, Fallon, Garfield,  
McCone, Powder River,  
Prairie, Richland,  
Roosevelt, Rosebud,  
Sheridan, Valley, Wibaux

## SECTION:

APPENDIX

## SUBJECT:

Directory of Regional Program  
OfficersREGIONAL PROGRAM  
OFFICERS

Nancy Mortag  
 Deljean Wadsworth  
 DPHHS District Office  
 201 1<sup>st</sup> Street South  
 Great Falls, MT 59405  
 Nancy: 453-8902  
 E-mail: nmortag@state.mt.us  
 Deljean: 453-8975  
 E-mail: dwadsworth@state.mt.us  
 Fax: 454-6084

Diane English-Castona  
 DPHHS District Office  
 3075 North Montana Ave.  
 PO Box 202958  
 Helena, MT 59620-2958  
 Phone: 444-1707  
 Fax: 444-9659  
 E-mail: denglishcastona@state.mt.us

Richard Rough  
 DPHHS District Office  
 P.O. Box 2357  
 Kalispell, MT 59903-2357  
 Phone: 755-5420  
 Fax: 751-5944  
 E-mail: rrough@state.mt.us

Amy Gentry  
 Lisa Hofman  
 DPHHS District Office  
 2677 Palmer, Ste 240  
 Missoula, MT 59808  
 Amy: 329-1312  
 E-mail: agentry@state.mt.us  
 Herb: 329-1310  
 E-mail: lhofman@state.mt.us  
 Fax: 329-1313

COUNTIES OF COVERAGE

Cascade, Hill, Chouteau,  
 Teton, Pondera, Fergus,  
 Petroleum, Judith Basin,  
 Blaine, Glacier, Toole,  
 Liberty, Phillips

Lewis & Clark, Broadwater,  
 Jefferson, Meagher,  
 Powell, Montana State  
 Hospital-Long Term Care  
 Unit

Flathead, Lincoln, Lake  
 Sanders

Missoula, Mineral,  
 Ravalli

o o o

Updated 03/01/96

g:\data\fa\addata\suppteam\codir.lis

PLEASE NOTIFY WENDY OLSON AT 444-3769 OF ANY CHANGES IN NAMES, ADDRESS, AND/OR PHONE NUMBERS

**FAMILY ASSISTANCE DIVISION**  
**County Directors**

<b><u>COUNTY DIRECTOR</u></b>	<b><u>COUNTY/#</u></b>	<b><u>MAILING ADDRESS</u></b>
<b>JIM FAY</b> Phone: 683-2142 FAX: 683-5776 Supervisor: None	<i>Beaverhead</i> (01)	2 South Pacific CL9 Dillon MT 59725
<b>JEAN KUKES</b> Phone: 665-1907 FAX: 665-1025 Supervisor and County Contact: <i>Lee Joyce Denny</i>	<i>Big Horn</i> (02)	PO Box 426 809 Custer Avenue Hardin MT 59034
<b>TIM WHITNEY</b> Phone: 357-2276 FAX: 357-2199 Supervisor: None County Contacts: <i>Kathy Molyneaux, Charlotte Brunner</i>	<i>Blaine</i> (03)	Courthouse Annex PO Box 1088 Chinook MT 59523
<b>JUANITA MALLO</b> Phone: 266-3157 FAX: 266-3674 Supervisor: None	<i>Broadwater</i> (04)	124 North Cedar Townsend MT 59644
<b>MARY NEWMAN</b> Phone: 446-1302 FAX: 446-2640 Supervisor: None	<i>Carbon</i> (05)	206 North Broadway PO Box 670 Red Lodge MT 59068
<b>GEORGE SHANLEY</b> Phone: 454-5640 FAX: 454-5697 Administrative Officer: Jerry Medved Supervisors: <i>Cheryl Klette, Lynette Bolender, Betty Pettibone</i> County Contacts: <i>Cheryl Klette, Jerry Medved, Lynette Bolender, Betty Pettibone</i>	<i>Cascade</i> (07)	PO Box 1546 1601 2nd Avenue North Great Falls MT 59403
<b>TIM WHITNEY</b> Phone: 622-5432 FAX: 622-3848 Supervisor: None	<i>Chouteau</i> (08)	1020 13th Street PO Box 459 Fort Benton MT 59442



**SUE MATTHEWS**

Phone: 232-7800

FAX: 232-7477 or 232-7803

Supervisor: None

County Contacts:

*Lucy Homme (Custer)*Margie Feickert (all other  
Counties)*Custer*

(09)

*Powder River*

(38)

*Garfield*

(17)

*McCone*

(29)

*Prairie*

(40)

1010 Main Street

Courthouse Basement

Miles City MT 59301

**JOAN BRENNER**

Phone: 365-4314

FAX: 365-5917

Supervisor: None

County Contacts: *Tara Doll, Maureen Mercier**Dawson*

(11)

207 West Bell

Glendive MT 59330

**PATTY GUIBERSON**

Phone: 563-3448 FAX: 563-7279

(FAX: Powell 846-3257)Supervisor: *Judy Barber/Deer Lodge* (39)Supervisor: *Mary Pat Brown/Powell Granite*  
(20)*Deer Lodge*

(12)

*Powell*

307 East Park, Room 305

Anaconda MT 59711

**BETTY MUELLER**

Phone: 778-2883

FAX: 778-2815

Supervisor: None

County Contact: *Doris Hastig**Fallon*

(13)

*Carter*

(06)

*Wibaux*

(55)

10 West Fallon Avenue

PO Box 759

Baker MT 59313

**BONI BRAUNBECK**

Phone: 538-7468

FAX: 538-8419

Supervisor: *Barb Gilskey*

County Contacts:

*Barb Gilskey,**LaVonne Rook (Musselshell)**Fergus*

(14)

*Musselshell*

(33)

*Judith Basin*

(23)

*Petroleum*

(35)

*Wheatland*

(54)

*Golden Valley*

(19)

300 1st Ave. N. Suite 201

Lewistown MT 59457

**JOHN (RULON) GARDNER**

Phone: 755-1515

FAX: 257-5423

Supervisors: *Judi Yeats, Gloria Stimson, Jill Nelson**Flathead*

(15)

2282 Highway 93 South

PO Box 1096

Kalispell MT 59901

<b>JOAN DAVIES</b>	<i>Gallatin</i>	Courthouse Room 300
Phone: 582-3010	(16)	Bozeman MT 59715
FAX: 582-3003		
Supervisors: <i>Deb Gorski, David Henley</i>		

<b>EVA BURNEY</b>	<i>Glacier</i>	1210 East Main
Phone: Cut Bank 873-4113	(18)	Courthouse Annex
FAX: Cut Bank 873-4706		Cut Bank MT 59427
Phone: Browning 338-5131		
Supervisor: <i>Sandra Sanderville</i>		
County Contacts: <i>Vicki Wilkins</i> (Cut Bank)		
<i>Sandra Sanderville</i> (Browning)		

<b>TIM WHITNEY</b>	<i>Hill</i>	Courthouse
Phone: 265-4348	(21)	302 4th Avenue
FAX: 265-6919	<i>Liberty</i>	Havre MT 59501
Supervisor: <i>Shirley Briese</i>		
County Contacts:		
<i>Shirley Briese, Valerie Golden</i>		

<b>JIM FAY</b>	<i>Jefferson</i>	Courthouse Annex
Phone: 225-4251	(22)	PO Box 836
FAX: 225-3327		Boulder MT 59632
Supervisor: <i>None</i> County Contact: <i>Jennifer Wise</i>		

<b>MARILYN BECKER</b>	<i>Lake</i>	8th and Main
Phone: 883-7820	(24)	PO Box 847
FAX: 883-5320		Polson MT 59860
Supervisors: <i>Sharon White, Luella Anderson</i>		

<b>JIM GREER</b>	<i>Lewis &amp; Clark</i>	PO Box 5029
Phone: 444-1700	(25)	3075 North Montana
FAX: 444-1751		Helena MT 59604
Administrative Officer: <i>Deborah Christiansen</i>		
Supervisors: <i>Linda Blixt, Deborah Christiansen, Carol Carpenter</i>		

<b>SUSAN GOSNEY</b>	<i>Lincoln</i>	117 Commerce Way
Phone: 293-3791	(27)	Libby MT 59923
FAX: 293-5549		
Supervisor: <i>Marlys Urdahl</i>		

<b>EMERY SMITH</b>	<i>Madison</i>	Courthouse
Phone: 843-5324	(28)	PO Box 75
FAX: 843-5325		Virginia City MT 59755
Supervisor: <i>None</i>		
County Contact: <i>Patricia Pedula</i>		

**CAROLE GRAHAM** *Missoula* 301 West Alder  
 Phone: 523-4950 (32) Missoula MT 59802  
 FAX: (Missoula) 721-4527 *Mineral*  
 Phone: Mineral 822-3217 (31)  
 Supervisors: *Dia Erickson, Terryann McCoy, Susan Rutherford, Karen Jirsa*

**JUANITA MALLO** *Park* 217 South Main Street  
 Phone: 222-8000 (34) Livingston MT 59047  
 FAX: (Park) 222-5742  
 FAX: (Meagher) 547-3388 *Meagher*  
 Supervisor: None (30)  
 County Contact: *Nancy Clark*

**DARLENE MILLER** *Pondera* Courthouse  
 Phone: 278-4020 (37) 20 4th Avenue SW  
 FAX: (Pondera) 278-3565 Conrad MT 59425  
 Phone: Teton 466-5721 (50)  
 FAX: (Teton) 466-2138  
 Phone: Toole 434-2371 (51)  
 FAX: (Toole) 434-2467  
 Supervisor: None / County Contacts:  
*Donna Payovich (Teton), Helen Long (Toole)*

**MARY LOVERIDGE** *Ravalli* 310 North 3rd Street  
 Phone: 363-1944 (41) Hamilton MT 59840  
 FAX: 363-2138  
 Supervisor: *Jeri Drake*

**LENA NEER** *Richland* 221 5th Street SW  
 Phone: 482-2282 (42) Sidney MT 59270  
 FAX: 482-2015  
 Supervisor: None / County Contacts:  
*Kym Braaten, Jarri Callen*

**J.T. BROWNLEE** *Roosevelt* Courthouse Building  
 Phone: 653-1210 (43) Wolf Point MT 59201  
 FAX: 653-2057 *Sheridan*  
 Supervisor: None (46)  
 County Contacts: *Daniels*  
*Kali Lien (Roosevelt)* (10)  
*Debra Maier (Sheridan)*

**BARBARA ROLSTON** *Rosebud* PO Box 5016  
 Phone: 356-2563 (44) Forsyth MT 59327  
 FAX: 356-7166 *Treasure*  
 County Contact: *Gloria Polley* (52)

**THORNE JOHNSON** *Sanders* Courthouse  
 Phone: 827-4395 (45) PO Box 519  
 FAX: 827-4388 Thompson Falls MT 59873  
 Supervisor: None / County Contacts: *Marcie Wollaston, Jeanne Holleran*

**JIM FAY**

Phone: 496-4900

FAX: 782-8728

Supervisors: *Mary Kay McGinnis, Colleen Kamensky*

*Silver Bow*

(47)

700 Casey Street

Butte MT 59701

**NANCY AMBROSE**

Phone: 322-5331

FAX: 322-4698

Supervisor: None

County Contacts:

*Carol Becken, Judie DeBock*

*Stillwater*

(48)

*Sweet Grass*

(49)

34 North 4th Street

PO Box 928

Columbus MT 59019

**LINDA NYBAKKEN**

Phone: 228-8221

FAX: (Valley) 228-4030

Supervisor: None

County Contacts:

*Sue Henderson, Pat Hallet (Valley), June Cornell (Phillips)*

*Valley*

(53)

*Phillips - FAX: 654-2254*

(36)

Courthouse Annex

501 Court Square

PO Box 9

Glasgow MT 59230

**GARY HUFFMASTER**

Phone: 256-6950

FAX: 256-6996

Supervisors: *Patricia West, Lyn Van Arsdale, Marilyn Brush, Jan Patenade*

County Contacts: *Lori Kellim, Patricia West, Lyn Van Arsdale, Marilyn Brush, Jan Patenaude*

*Yellowstone*

(56)

111 North 31st Street

Billings MT 59101





**MONTANA MEDICAID PROGRAM**

**Department of Public Health and Human Services**

**Laurie Ekanger, Director**

**Health Policy and Services Division**

**Nancy Ellery, Administrator**

**PO Box 202951, 1400 Broadway  
Cogswell Building, Room A206  
Helena, MT 59620-2951  
(406) 444- 4540**

**May 1999**

## **MISSION STATEMENT**

**To assure that necessary medical care is available to all eligible low income Montanans.**

**In order to fulfill its mission, the Medicaid program must:**

- promote the maintenance of good health by program recipients;**
- assure recipients have access to necessary medical care;**
- assure that quality of care meets acceptable standards;**
- promote the appropriate use of services by recipients;**
- promote the delivery of appropriate care by service providers;**
- assure that service providers are paid quickly and accurately; and**
- assure that services are purchased in a cost-effective manner.**

## SERVICE DELIVERY COORDINATION

The delivery of services and administrative activities of the Medicaid Program are located primarily within the Health Services and Policy Division. These services are coordinated with many other divisions in the Department of Public Health and Human Services (DPHHS) as well as other state and federal agencies and private providers. Determination of Medicaid eligibility is administered by the DPHHS Division of Child and Family Services through the local County Welfare/Human Services. Eligibility questions should be directed to these offices. Mental health services are administered by the DPHHS Addictive & Mental Disorders Division. Long-term care services are administered by the DPHHS Senior and Long Term Care Division. Utilization review is administered by the DPHHS Quality Assurance Division.

The Division contracts with Consultec, Inc. to enroll Medicaid providers and process Medicaid claims. Consultec's toll free phone number is 1-800-624-3958.

The Division contracts with Unisys to perform much of the administrative oversight for Passport and the HMO Program. Part of their duties include operating a toll free recipient hotline 1-800-362-8312 and a toll free provider hotline 1-800-480-6823.

## GENERAL STATEMENT/CO-PAYMENT

Recipients are responsible for paying the co-payment amounts designated by Medicaid. CHILDREN (under age 21), PREGNANT WOMEN, and NURSING HOME RESIDENTS ARE EXEMPT from co-payments. Co-payments MAY NOT be charged for services provided in an emergency or for family planning.



## SERVICE

## SCOPE

## LIMITATIONS

## REIMBURSEMENT

## COPAY

1. <b>Ambulatory Surgical Centers</b> Bob Wallace 444-7018)	Selected procedures provided on an out-patient basis.	ASC must be licensed and meet Medicare participation standards.	Department fee schedule does not include physician services, ambulance, or major prosthetic appliances.	\$1.00 per visit..
2. <b>Audiology Services</b> (ARM 46.12.533) Linda Van Diest 444-4066	Hearing aid evaluation only.	Ordered by physician or mid-level practitioner.	Department fee schedule.	\$1.00 per service.
3. <b>Chemical Dependency Treatment Services (Outpatient)</b> Michelle Gillespie 444-3182	Intensive outpatient, basic outpatient and aftercare services.	-Must be determined appropriate by a Certified Chemical Dependency Counselor. -L. limited to individuals under 21 years of age. -Providers must be approved by Dept. Of Corrections and Human Services.	Department fee schedule.	Exempt.
4. <b>Chiropractic Services</b> (ARM 46.12.515) Michelle Gillespie 444-3182	Manual manipulation of the spine and limited x-rays.	L. limited to individuals under age 21.	Department fee schedule.	Exempt.
5. <b>CLINICS</b> <b>Diagnostic Clinic</b> (ARM 46.12.570, 571, 573) Randy Bowsher 444-3995	Evaluation services in diagnosis and evaluation centers.	Services cannot exceed amount, duration, and scope of services outside clinic setting.	Department fee schedule.	\$1.00 per visit.
<b>Federally Qualified Health Centers (FQHC)</b> (ARM 46.12.1701, 1703, 1705 and 1707) Debra Stipcich 444-4834	Medicaid covered ambulatory services.	Federally deemed clinic receiving or qualified to receive funds under Section 329, 330 or 340 of the Public Health Service Act.	100% of reasonable cost through an all inclusive interim rate and end of period cost settlement.	\$2.00 per visit.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

<b>Freestanding Dialysis Clinics</b> (ARM 46.12.1501 and 1505)  Debra Stipcich 444-4834	Outpatient maintenance dialysis; training for self dialysis and home dialysis.	Coordinated with Medicare renal disease program; patients must be diagnosed as suffering from chronic ESRD.	All inclusive composite rate for services with a separate fee for drugs.	\$2.00 per visit.
<b>Public Health Clinics</b> (ARM 46.12.570, 570 & 573)  Linda Van Diest 444-4066	Outpatient physician, nurse specialist, physician assistant, nursing services.		Department fee schedule	\$1.00 per visit.
<b>Rural Health Clinics (RHC)</b> (ARM 46.12.1601, 1603, 1605 & 1607)  Debra Stipcich 444-4834	Outpatient services not including dental provided by hospital affiliated-Provider Clinic-or free standing-Independent-clinic.	Medicare certified Clinic located in rural area designated a shortage area by HHS; not a rehab or primarily a facility to treat mental diseases.	Provider Clinics-100% of reason- able cost; Independent Clinics-100% of reasonable cost through an all inclusive interim rate not to exceed an annual cap set by HHS	\$2.00 per visit.
<b>Mental Health Services</b> <i>Addictive &amp; Mental Disorders</i> Randy Poulsen 444-2706  <i>Montana Community Partners,</i> Contractor 1-888-599-2233 (recipients) 1-800-926-6636 (providers)	All services medically necessary in the treatment of a specific range of mental illness diagnoses are provided through the Mental Health Access Plan, the state's managed care program, which is operated by Montana Community Partners.	Most services must be pre-authorized. A recipient's first 15 outpatient therapy or medication management sessions do not require authorization..	According to provider's contract with Montana Community Partners.	Exempt.
6. <b>Dental services</b> , including denture services provided by denturists (ARM 46.12.601)  Michelle Gillespie 444-3182	Services listed in Department rules.	-Extensive dental services, including dentures, must be prior authorized by the Department. -Services provided by a denturist must be prescribed by a dentist	Department fee schedule.	\$1.00 per service.
7. <b>Dietitian Services</b>  Michelle Gillespie 444-3182	Evaluation and treatment by a licensed nutritionist or dietitian	Limited to individuals under 21 years of age.	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
8. <b>Optometric services</b> (ARM 46.12.901, 902, 905, 911 and 912)  Linda Van Diest 444-4066	Services listed in Department rules.	-Eye examination limited to one annually.	Department fee schedule	\$1.00 per service
9. <b>Eyeglasses</b> (ARM 46.12.901, 902, 905, 911 & 912).  Linda Van Diest 444-4066	Services and items listed in Department Rules.	-One pair of eyeglasses every two years for individuals 21 and over, unless there's a significant change in prescription or the individual has had cataract surgery.  -Eyeglasses are through Volume Purchasing Contract.	Department fee schedule	\$0 for Eyeglasses. \$1.00 per dispensing fee.
10. <b>Family Planning Services</b> (ARM 46.12.575)  Randy Bowsher 444-3995	Family planning services and supplies for individuals of child-bearing age provided by Title X Family Planning Clinics.	-Sterilizations/abortions limited by federal requirements.	Department fee schedule.	Exempt.
11. <b>Health Maintenance Organizations (HMOs)</b>  Maureen O'Reilly 444-4148	Services and items listed in Department Rules.	Only certain services are managed by the HMO. Limited to certain geographic areas.	Per contract.	Exempt for HMO covered service.
12. <b>Hearing Aids</b> (ARM 46.12.540)  Linda Van Diest 444-4066	Hearing Aids, repairs, and accessories.	-Ordered by physician or mid-level practitioner. -Prior authorized by the Department. -Hearing evaluation required by audiologist.	Department fee schedule.	\$1.00 per service.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID



<p>13. <b>Home and Community Based Services (HCBS Medicaid Waiver)</b> (ARM 46.12.1401)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Cecilia Cowie 444-4150</p> <p>Annette Marron 444-4142 Claims Resolution</p>	<p>In-home services designed to serve individuals in the community who would otherwise require nursing home or hospital care. Services include case management, homemaker, personal care, respite, adult day care, medical alert, environmental modifications/ adaptive equipment, meals, dietitian, social transportation, habilitation, respiratory therapy, nursing &amp; psychological consultation, adult residential, child care for children with AIDS &amp; special services for individuals with a traumatic brain injury.</p>	<p>-Recipient must meet nursing home or hospital level of care and services must be ordered by a physician. -Medicaid cost of care in community cannot exceed cost of institutional care.</p>	<p>Reimbursement varies by service.</p>	<p>Exempt.</p>
<p>14. <b>Home Health Services</b> (ARM 46.12.550)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Barbara Smith 444-4064</p>	<p>Intermittent skilled nursing services, home health aide services, physical, occupational &amp; speech therapy services and supplies related to services delivered.</p>	<p>-Ordered by a physician. -Limited to a combined maximum 100 visits per state fiscal year except nursing services which have a limit of 75 visits per recipient per state fiscal year. More nursing visits may be available with prior authorization. -All Home Health Aid services must be prior authorized. -Recipient must be homebound OR cannot readily obtain needed medical services other than through a Home Health Agency. -Recipient receiving PCA services may not receive home health aid services.</p>	<p>Department Fee Schedule</p>	<p>\$2.00 per service. \$.50 per item for equipment and supplies.</p>

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID



<p>15. <b>Home Dialysis Attendant Services</b> (ARM 46.12.560)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Barbara Smith 444-4064</p>	<p>Payment for trained dialysis attendants to assist dialyzing recipients at home.</p>	<ul style="list-style-type: none"> <li>-Provided only to recipients diagnosed by a physician as suffering from chronic end stage renal disease.</li> <li>-Provided only when there is no family member who can be trained to perform the dialysis.</li> <li>-Attendants must be licensed RN or LPN trained by home dialysis training center.</li> </ul>	<p>Department fee schedule</p>	<p>Exempt.</p>
<p>16. <b>Hospice</b> (ARM 46.12.1819)</p> <p><i>Senior &amp; Long Term Care Div</i></p> <p>Barbara Smith 444-4064</p>	<p>Services and terms listed in Department rules.</p>	<ul style="list-style-type: none"> <li>-All services related to terminal condition to be provided by Hospice except for attending physician, personal care and HCBS waiver.</li> </ul>	<p>Federally set rates</p>	<p>Exempt.</p>
<p>17. <b>Hospital</b></p> <p><b>In-Patient Hospital Services</b> (ARM 46.12.503)</p> <p>Jane Bernard 444-2528 Reimbursement and coverage</p> <p><i>Quality Assurance Div.</i></p> <p>Carol Jorgensen 444-0190 Utilization review</p>	<p>Medically necessary services ordinarily furnished in a hospital, including:</p> <ul style="list-style-type: none"> <li>-bed and board</li> <li>-nursing and other related services</li> <li>-use of hospital facilities</li> <li>-medical social services</li> <li>-drugs, biologicals, supplies, appliances and equipment</li> <li>-other diagnostic or therapeutic items or services</li> <li>-medical or surgical services provided by interns and residents-in-training</li> </ul>	<ul style="list-style-type: none"> <li>-Limited to medically necessary days, except drug/alcohol detox limited to four days unless condition requiring hospital care</li> <li>-Sterilization/abortions limited by federal requirements.</li> <li>-Acute Care Rehabilitation Units and Psychiatric Units.</li> <li>-Admissions subject to preadmission review by the department's designee or peer review organization.</li> <li>-Transplant services limited to Medicare approved facilities.</li> </ul>	<p>Prospective system based on diagnostic related groups (DRGs) for in-state and border hospitals. Cost based for free-standing psychiatric hospitals, distinct part rehabilitation units and out-of-state hospitals</p>	<p>\$100.00 per discharge from the hospital.</p>

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

<b>Out-Patient Hospital Services</b> (ARM 46.12.506)  Jane Bernard 444-2528	Medically necessary preventive, diagnostic, therapeutic, rehabilitative and palliative services.	-Limited to emergency room services and services covered by Medicaid in non-hospital setting and ordered by or under the direction of a physician.	Prospective payment for ER, ambulatory surgery, dialysis, laboratory, imaging and other diagnostic services. Retrospective reimbursement for all other outpatient services, (Rural hospitals & MAFs are not subject to prospective payment.	\$1.00 per line item.
<b>19. In-Patient Rehabilitation (Physical) Services</b>  Jane Bernard 444-2528 Reimbursement & Coverage  <i>Quality Assurance Division</i> Carol Jorgensen 444-0190 Joan Ashley 444-4121  <i>Senior &amp; Long Term Care</i> Kelly Williams 444-4147 Skilled Nursing Facilities Utilization Review  <i>Prior Authorization</i> Mountain Pacific Quality Health Foundation 443-4020 1-800-262-1545	Medically necessary services provided in the following settings: 1. Medicare certified hospitals; or 2. Medicare certified skilled nursing facility.	-Limited to acute care rehabilitation. -Limited to medically necessary days. -Rehabilitation centers which do not meet Medicare certification specified in "scope" are not covered. -Hospital admissions must be prior authorized by the Department's peer review organization. -Nursing home admissions must be prior authorized by the Department.	Cost-based.	Dependent of type of facility. See hospitals or nursing homes.
<b>20. Early, Periodic Screening Diagnosis &amp; Treatment (EPSDT)</b> (ARM 46.12.514, 515, 516)  Michelle Gillespie 444-3182	Screening and diagnostic services to determine and treat physical and mental illness or handicap.	Limited to individuals under 21 years of age.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

<p>21. <b>Medical supplies, prosthetic devices, and durable medical equipment</b> (ARM 46.12.801)</p> <p>Frank Malek 444-4068 Coverage &amp; Reimbursement</p> <p><i>Quality Assurance Division</i></p> <p>Carol Jorgensen 444-0190</p> <p>PA for Air Fluidized Beds, Augmentative Communication Devices, Hospital Beds Purchase), Wheelchairs &amp; Items costing \$1,000 or more.)</p>	<p>Items listed in Department rules.</p>	<p>-Prior authorization as indicated in ARM. -Ordered by a physician.</p>	<p>Department fee schedule</p>	<p>\$.50 per item.</p>
<p>22. <b>Mid-Level Practitioner Services</b> (ARM 46.12.2010)</p> <p>Randy Bowsheer 444-3995</p>	<p>Limited to services provided within the scope of practice allowed by state law.</p>	<p>Services must be provided: 1. Within the level of physician supervision required by law; 2. Delivery of babies by nurse midwives must be in a licensed facility.</p>	<p>Department fee schedule.</p>	<p>\$2.00 per service. (Pregnant women are Exempt.)</p>
<p>23. <b>Other laboratory and X-ray Services</b></p> <p>Randy Bowsheer 444-3995</p>	<p>Laboratory and x-ray services performed in a physician's office or in a free-standing facility, including a hospital acting as an independent laboratory. Services may not be provided in a hospital outpatient department or clinic.</p>	<p>Laboratory and radiology services as ordered by a physician, dentist or optometrist.</p>	<p>Department fee schedule, or for laboratory services, 60 percent of the Medicare prevailing whichever is lower.</p>	<p>\$2.00 per service in a physician's office.</p>

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

<div> <div> 24. Out-of-State Services (ARM 46.12.502)   <i>Quality Assurance Division</i>  Joan Ashley 444-4121   <i>Prior Authorization</i>  Mountain Pacific Quality  Health Foundation   443-4020  1-800-262-1545 </div> </div>	All Medicaid Services which are not available in-state or within 100 miles of MT border subject to limitations specified in the next column.	<div> -Out-of-state services are subject to the same limitations of the Montana Medicaid Program as in-state services.  -May not go beyond 100 miles of the MT border for services, if the same services are available within that boundary.  -Out-of-state services are allowed only when:  there is a medical emergency and the recipient's health would be endangered if he were required to travel to Montana to obtain the medical services;  the recipient travels to another state because the Department finds the required medical services are not available in Montana; or it is determined by the Department that it is general practice of recipients in a particular locality to use medical resources in another state;  the recipient or his representative can demonstrate to the satisfaction of the Department that out-of-state medical services and all related expenses will be less costly than in-state services; or  the recipient is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments.  Inpatient services subject to preadmission review by the Department's peer review organization or designee. </div>	Determined by type of service.	Amount is dependent on type of service provided. Refer to specific service for co-pay amount.
--	--	--	--------------------------------	---

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID



SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
25. <b>Outpatient Drugs</b> (ARM 46.12.701)  Dorothy Poulsen 444-2738  Betty DeVaney 444-3457 Manufacturers Rebate	Drugs approved by FDA and requiring a prescription and over-the-counter drugs which are insulin, aspirin, laxatives and antacids.	-Prescribed by licensed practitioner. -Less-than -effective and experimental drugs are not covered. -Specific classes of drugs are limited to formulary products unless PA is obtained.	Maximum allowable cost (MAC) or estimated acquisition cost (EAC) plus dispensing fee.	\$1.00 per prescription Generic. \$2.00 per prescription brand name.
26. <b>Home Infusion Therapy</b> Rule # not yet assigned.  Dorothy Poulsen 444-2738	Services listed in Dept. Rules, provided by licensed home infusion therapy providers.	Prescribed by licensed practitioner. Specific therapies as limited by Dept. Rule. May not be provided in a hospital.	Pharmacy - see outpatient drugs. Nursing - Home Health or PDN per Diem - Department fee schedule.	Pharmacy - Exempt Nursing - See Home Health or PDN Per diem \$.50 per unit.
27. <b>Outpatient physical therapy, speech therapy and occupational therapy</b> (ARM 46.12.525A-46.12.527A)  Linda Van Diest 444-4066	Services listed in Department rules.	-Ordered by physician or mid-level practitioner -PT, ST & OT services limited to 70 hours per year without prior authorization by the Department. An additional 30 hours if determined medically necessary by the Department.	Department fee schedule.	\$1.00 per hour.
28. <b>PASSPORT TO HEALTH</b>  Maureen O'Reilly 444-4148	Recipients choose primary care provider who manages their care.	Limited to specific geographic areas of coverage, only certain services will be managed by primary care provider, refer to Department rules.	Department fee schedule.	Same as without PASSPORT.
29. <b>Personal Assistant Services</b> (ARM 46.12.555)  <i>Senior &amp; Long Term Care</i>  Barbara Smith 444-4064	In-home services, including assistance with basic personal care functions such as bathing, grooming, dressing, toileting, transferring, walking, meal preparation, feeding, help with self-administered medications, escort to obtain medical care. Some assistance with home management.	-Ordered by physician. -Supervised by licensed nurse at least 180 days. -May not be provided in a long-term care facility, including a licensed personal care facility. -Limited to 40 hours per week.	Department fee schedule.	Exempt.

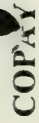
EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID



## SCOPE

## LIMITATIONS

## REIMBURSEMENT



Self-Directed Personal Assistance Services. (ARM 46.12.555) <i>Senior &amp; Long Term Care Div.</i> Barbara Smith 444-4064	Client-directed personal assistance services.	-Ordered by a physician or health care professional.	Department fee schedule.	Exempt.
30. <b>Physician's Services</b> (ARM 46.12.1201) Randy Bowsher 444-3995 Fran O'Hara 444-3337 Claims Resolution	Services within the scope of the practice of medicine or osteopathy.	-Sterilizations/abortions limited by federal requirements. -Cosmetic services are not covered unless severe impairment to patient's physical and psycho-social well-being is demonstrated and treatment is prior authorized by the Department. -Treatment of infertility is not covered.	Department fee schedule.	\$2.00 per service.
31. <b>Podiatry Services</b> (ARM 46.12.521) Randy Bowsher 444-3995	Services listed in Department rules.		Department fee schedule.	\$2.00 per service.
32. <b>Presumptive Eligibility</b> (ARM 46.12.3401) Wendy Olson 444-4189	Ambulatory prenatal care for a time period of less than two months while formal application for public assistance is being made.	Ambulatory prenatal care (Approved Medicaid Services).	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

SERVICE	SCOPE	LIMITATIONS	REIMBURSEMENT	COPAY
<b>33. Private Duty Nursing Non-Hospital Services</b> (ARM 46.12.565)  Michelle Gillespie 444-3182 Reimbursement & coverage  <i>Quality Assurance Division</i>  Carol Jorgensen 444-0190 Utilization review.	Skilled nursing services outside of a hospital which includes RN and LPN services.	-Ordered by a physician. -Prior authorized by Department. -Recipients must be under 21 years of age or receiving as part of home infusion therapy. -Respite care is not covered.	Department fee schedule.	Exempt, except for home infusion therapy
<b>35. QDWI ( Qualified Disabled &amp; Working Individual)</b>  Wendy Olson 444-4189	Medicaid pays Medicare Part A premiums.			
<b>36. QMB (Qualified Medicare Beneficiary)</b>  Kathy Demme 444-4871	Medicaid pays Medicare premium, co-insurance and deductibles.		Up to Medicaid allowable charge or rate.	Established by service item.
<b>37. Respiratory Therapy Services</b>  Frank Malek 444-4068	Treatment in the home by a Licensed Respiratory Care Practitioner.	-Ordered by a physician. -Limited to individuals under 21 years of age/	Department fee schedule	Exempt.
<b>38. School Based Services</b>  Jeff Buska 444-4145	Medical care provided for children in a school setting.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
<b>39. Skilled and intermediate nursing services in long term care facilities.</b>  <i>Senior &amp; Long Term Care</i>  Steve Blazina 444-4129	Meal services, medications, nursing and other health services, rehabilitative services, social services and activities programs.	-Ordered by a physician. -Certified by Department for level of care prior to admission/payment.	-Prospective per diem rate, composed of operating, direct nursing and property rates. -Prescription drugs & rehabilitation services (OT, PT, ST) are reimbursed on a fee schedule basis. Other ancillaries are reimbursed at provider acquisition cost.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID



40. <b>Out of State Nursing Homes</b> (ARM 46.12.1251)  <i>Senior &amp; Long Term Care</i>  Kelly Williams 444-4147	Same as above.	Physician ordered prior approval by Department level of care certified.	Rate established by the State Medicaid agency in the state where facility is located.	Exempt.
41. <b>Swing Beds</b>  <i>Senior &amp; Long Term Care</i>  Kelly Williams 444-4147	LTC Services provided in swing beds when no NF beds are available in community & resident meets level of care.	No NF beds available in 25 mile radius of discharging hospital. Must be NF level of care.	Prior calendar year statewide average Medicaid rate for nursing facilities. (NF)	Exempt.
42. <b>Targeted Case Management</b> (ARM 46.12.1901-1940)  Shari Pettit (HPSD) 444-2574 Pregnant Women Special Health Needs  <i>Disability Determination Division</i> James Driggers 444-4090 Developmentally Delayed  <i>Addictive &amp; Mental Disorders Div.</i> Randy Poulsen 444-2706 Adults with Chronic Mental Illness, Severely Emotionally Disturbed Children.	Services designed to assist individuals in accessing needed medical, social, educational and vocational services. The four target groups covered are: -Pregnant women and infants through 1 year of life.  -Individuals 16 years of age and older with developmental delays.  -Individuals 18 years of age and older with severe mental illness. -Individuals up to 18 years of age with severe emotional disturbance.		Department fee schedule.	Exempt.



<p>44. <b>Transportation and per diem/Ambulance</b> (ARM 46.12.1001-1025)</p> <p>Kathy Demme 444-4871 Reimbursement &amp; Coverage</p> <p>Prior Authorization: Mountain Pacific Quality Health Foundation</p> <p>1-800-292-7114</p>	<p>Ambulance services, air transport, specialized non-emergency transportation services, commercial transportation, mileage and per diem.</p>	<ul style="list-style-type: none"> <li>-All non-emergency transportation must be prior authorized by MWPMC.</li> <li>-Ambulance must be licensed under state law.</li> <li>-Ambulances are covered for emergency care and for non-emergency care when the patient is stretcher-bound and the ambulance is ordered by a physician.</li> <li>-Transportation is only covered to obtain medically necessary services from nearest provider.</li> <li>-Transportation is limited to the least expensive means suitable to meet the recipient's needs.</li> </ul>	<p>Department fee schedule.</p>	<p>\$1.00 per trip Specialized non-emergency.</p>
<p>45. <b>Indian Health Services</b> (Sec. 1905B, 1911A of the Social Security Act.)</p> <p>Debra Stipcich 444-4834</p>	<p>Services provided by Indian Health Service Facilities.</p>	<p>Outpatient and Inpatient Services.</p>	<p>Fees set by HCFA annually per visit for outpatient per diem for inpatient.</p>	<p>Exempt.</p>
<p>46. <b>Health Insurance Premium Payment</b></p> <p><i>Quality Assurance Div. - TPL</i></p> <p>1-800-457-1978</p>	<p>Group and Individual Health Policies</p>	<p>Health Plan must be determined to be cost effective by TPL prior to reimbursement.</p>	<p>Determined by TPL.</p>	
<p>47. <b>Medicare Buy-In</b></p> <p><i>Quality Assurance Div - TPL</i></p> <p>Lynn Roberts 444-4552</p>	<p>Payment of Medicare premiums for QMB, SLMB, QDOW1 and SSI recipients.</p>	<p>Must be eligible for QMB, SLMB, QDOW1 or SSI related program.</p>	<p>Based on current year's Medicare premium rate as set by SSA.</p>	

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

Department of Public Health  
and Human Services

HOME AND COMMUNITY BASED  
SERVICES

SECTION:

GENERAL PROGRAM ADMINISTRATION

SUBJECT:

Civil Rights

GENERAL RULE--Title VI and Title IX of the Civil Rights Act requires that no person shall, on the grounds of race, color or national origin, creed, sex, religion, political ideas, marital status, age or handicap, be excluded from participating in, be denied benefits, or otherwise be subjected to discrimination under any program receiving federal funding.

Affirmative steps must be taken to employ and advance in employment qualified individuals with disabilities.

COMPLIANCE--All contracts with providers contain a section on civil rights. Providers shall comply with the Civil Right Act and the Montana Human Rights Act, Title 49, Chapter 2, MCA, as amended and all requirements imposed by or pursuant to the regulation.

o o o



Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Fair Hearings

**References:** ARM 46.2.201 - 46.2.214

REQUIREMENT--Any Medicaid provider or Medicaid recipient may appeal any adverse action which is felt to have affected the amount or scope of Medicaid payments received and/or eligibility for Medicaid.

REQUESTING FAIR HEARINGS--A recipient, provider or his official representative must request a hearing in writing and mail the request to the Department of Public Health and Human Services, Hearings Officer, P.O. Box 202951 Helena, MT 59620. A provider request must be postmarked or delivered to the Department no later than 30 calendar days following the date of notice of the determination. An applicant or recipient request must be postmarked or delivered no later than 90 calendar days following the date of Notice of Determination.

CONDUCTING FAIR HEARINGS--Fair Hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding and must conform to federal and state laws, regulation or policy and must be based exclusively on evidence and other material introduced at the hearing. A Fair Hearing will be preceded by an administrative review of the action. A pre-hearing conference may be held at the request of the Hearing Officer or the parties requesting the hearing.

ADMINISTRATIVE REVIEW--The purpose of the administrative review is for the Department to reconsider its proposed action. The requestor of the hearing will review the matter with the Department representative, present additional information to the Department concerning the action, and obtain additional explanations



## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Fair Hearings

from the Department on the reasons for the action. The Department will inform the individual of the determination after the administrative review has been completed.

PRE-HEARING CONFERENCE--The purposes of the pre-hearing conference are to consider simplification of the legal and factual issues in preparation for the hearing, obtain admissions of fact and documents, explore the possibility of settlement, establish what evidence and witnesses will be presented, and discuss any other matters which may aid in disposing of the Fair Hearing.

o o o

Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Release of Information/  
Confidentiality

REQUIREMENT--Federal law requires that Medicaid information about applicant/recipient and provider eligibility, or the amount of assistance and services provided is confidential. Under this protection, information regarding recipients cannot be released without their consent. Refer to Appendix 399-1 of this chapter for an example of a Consent Form.

Information released for purposes directly connected with administration of the Medicaid Program does not require recipient consent. This would include such activities as:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution or civil or criminal proceeding related to Medicaid fraud or abuse.

PROCEDURES--The case management team should develop procedures to ensure that confidentiality is maintained. The procedures must include at least the following:

1. A determination that the individual requesting information will be using it for purposes directly connected with administration of the Medicaid Program.
2. Documentation of the date, purpose and requesting individual/agency in the recipient record.

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Release of Information/  
Confidentiality

3. Denial of any request for recipient-related information unrelated to the administration of the Medicaid Program until a recipient signed and dated release of information is received.

COMPLIANCE--All contracts with providers contain a section on confidentiality. Providers agree to comply with confidentiality laws by contract.

All Department application forms state that the confidential information provided by the recipient will be protected and will only be used for purposes directly related to administration of the program.

FREEDOM OF INFORMATION--Recipients have a right to their own records.

o o o

Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Third Party Liability (TPL)

**Reference:** ARM 46.12.304 - 46.12.305

REQUIREMENT--According to state and federal law, the state must take all reasonable measures to determine the legal liability of third parties to pay for health care and services covered by Medicaid.

The Medicaid Program is the payor of last resort to other insurance programs. Medicaid does pay before Crime Victim Compensation funds and Indian Health.

If a third party source is known to the provider, the provider must bill the third party prior to billing Medicaid and indicate any amount received from the third party on the Medicaid claim. Providers must submit a copy of the statement of payment or denial from the resource when billing for any balance.

Examples of third party resources include the following:

- . Medicare
- . Veterans' Administration Medical Payment
- . Private Insurance
- . Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
- . Workers' Compensation

THIRD PARTY LIABILITY QUESTIONS--Questions about third party policy or claims submission should be directed to the TPL Unit of the Quality Assurance Division or Consultec's Provider Relations Section.

o o o





Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Fraud and Abuse

**Reference:** ARM 46.12.401 - 46.12.408

REQUIREMENT--The Department is charged by federal and state law with the responsibility of identifying, investigating and referring to law enforcement officials cases of suspected fraud or abuse of the Medicaid Program by either providers or recipients. Sanctions may be imposed against a Medicaid provider for reasons including but not limited to the following:

1. Submitting a false or fraudulent claim;
2. Failure to maintain and retain required records;
3. Failure to disclose or make available records to the Department;
4. Failure to provide and maintain the quality of services accepted within medical community standards;
5. Breach of the terms of the provider contract;
6. Submitting a false or fraudulent application for provider status;
7. Rebating or accepting a fee or charge for a Medicaid recipient referral;
8. Charging Medicaid recipients for amounts over and above the amounts paid by Medicaid; and/or
9. Failure to meet federal or state licensure or certification requirements.

REPORTING PROCEDURE--Cases of potential fraud and program abuse should be referred to the Department. All such referrals are held confidential and may be made anonymously.

o o o



Department of Public Health  
and Human Services

SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Surveillance and Utilization  
Review

REQUIREMENT--Federal regulations require states to develop and implement statewide surveillance and utilization control programs to promote the most effective and appropriate use of available services. Utilization control must include a post-payment review process for review of recipient utilization profiles and provider service profiles to identify and correct misutilization practices. The Department's Surveillance Utilization and Review Unit is responsible for claim surveillance and utilization review.

PROCEDURES--Procedures and mechanisms employed by the Surveillance Utilization and Review Unit include, but are not limited to the following:

- Review of recipient profiles of service utilization;
- Review of provider claims and payment history;
- Computer-generated listings of duplicate payments, conflicting dates of service and over-utilization;
- Internal checks on claim pricing, procedures, quantity, duration, deductibles, co-insurance, provider and recipient eligibility;
- Medical staff review and application of established medical service parameters;
- Field auditing activities; and
- Computer-generated comparative analysis by provider type.



## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Surveillance and Utilization  
Review

EXPLANATION OF MEDICAL BENEFITS (EOMB)  
PROGRAM--Every month the Department mails an EOMB to randomly selected recipients. The EOMB details services paid in the recipient's behalf during the previous month. The recipient is requested to verify the receipt of the services and return the form. If a recipient contacts the provider about an EOMB, the provider should refer the recipient to the Department's Surveillance Utilization and Review Unit.

o o o

Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Medicaid Management Informa-  
tion System (MMIS)

DEFINITION--The Medicaid Management Information System (MMIS) is an automated system of claims processing and information retrieval required to be used by State Medicaid Programs. It includes information on Medicaid providers, recipients and claims. Data regarding the Home and Community Based Services Program includes date, type, amount, frequency and cost of services, recipient identification and payment category.

USE OF MMIS DATA--The MMIS data on the Home and Community Based Services Program is available for review and reporting on expenditures. MMIS data is also used to produce utilization data and management information about Medicaid recipients and services. These reports are generated quarterly and are available for review upon written request to the Department.

o o o



Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Quality Assurance

Quality assurance reviews are conducted by the Case Management Teams (CMT), the Community Services Bureau of the Senior and Long Term Care Division, and the Audit and Compliance Bureau of the Quality Assurance Division.

**CASE MANAGEMENT  
TEAMS**

Case Management Teams are required to conduct chart audits at least quarterly on a sample of cases. No less than a ten percent (10%) random sample should be conducted when caseloads are at or near maximum. The sample size should be increased when caseloads are lower.

PROCEDURE--The audit findings from case reviews are reported on the Provider Prepared Standards which is Report 2 of the Quarterly Reporting Requirements. (Refer to HCBS 899-2.)

**COMMUNITY SERVICES  
BUREAU**

The Community Services Bureau of the Department conducts comprehensive evaluations of Case Management Teams to meet the Bureau's Quality Assurance requirements.

PROCEDURE--The evaluations will consist of some or all of the following components:

1. Performance Standards consisting of the standards outlined in HCBS 899-3, RPO - selected RFP Points, and CMT/RPO selected standards;
2. Provider Prepared Standards;
3. Home Visits;
4. Adult Protective Services and Fraud checks;
5. Financial audit conducted by the Department's Audit and Compliance Bureau;



## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Monitoring and Evaluation

6. Provider reference checks;
7. Information from the team's advisory council; and
8. A performance review consisting of:
  - a. Accumulated Performance Point Sheets;
  - b. Case Review Requests; and
  - c. Serious Occurrence Reports.

Components used will depend upon:

1. The availability of the data/information;
2. The team's previous review; and
3. The team's performance since their last review.

## AUDIT AND COMPLIANCE

## BUREAU

This bureau will conduct financial audits upon request of the Community Services Bureau.

o o o

Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Reporting Recipient Abuse and  
Neglect

DESCRIPTION--The case management team should know and understand the Elder Abuse Law and make referrals to the Adult Protect Services Program, if needed. Suspected abuse of any recipient must be reported to the Department. (Refer to Appendix 399-2 for a copy of the Social Service Manual 401-7 and 401-7a regarding elder abuse referral investigation.)

REQUIREMENT--As a Medicaid enrolled provider, you have a responsibility to report instances or suspected instances of abuse, neglect, or exploitation of HCBS recipients. Abuse results in scratches, cuts, bruises, burns, broken bones, bedsores, confinement, rape or sexual misconduct, and verbal and psychological abuse. Neglect results in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care, and personal hygiene. Exploitation is misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Abused elderly or people with disabilities may be: isolated, ill, and lack a capable or willing caregiver, or lack resources to meet their basic living requirements. Any aged or disabled adult who is in a state of abuse, neglect, or exploitation is eligible to receive adult protective services and must be referred to APS immediately. Children must be reported to Child Protective Services.

**What to Look For**

Here are some indicators that you should watch for. These descriptions are not necessarily proof of abuse, neglect, or exploitation. But

SECTION:

GENERAL PROGRAM  
ADMINISTRATION

SUBJECT:

Reporting Recipient Abuse and  
Neglect

they may be clues that a problem exists, and that a report needs to be made to law enforcement or Adult Protective or Child Protective Services.

Physical Signs

- injury that has not been cared for properly;
- injury that is inconsistent with explanation for its cause;
- pain from touching;
- cuts, puncture wounds, burns, bruises, welts;
- dehydration or malnutrition without illness-related cause;
- poor coloration;
- sunken eyes or cheeks;
- inappropriate administration of medication;
- soiled clothing or bed;
- frequent use of hospital or health care/doctor-shopping;
- lack of necessities such as food, water, or utilities;
- lack of personal effects, pleasant living environment, personal items; or
- forced isolation.

Behavioral Signs

- fear;
- anxiety, agitation;
- anger;
- isolation, withdrawal;
- depression;
- non-responsiveness, resignation, ambivalence;
- contradictory statements, implausible stories;
- hesitation to talk openly; or
- confusion or disorientation.

Signs of Abuse by Caregiver

- prevents elder from speaking to or seeing visitors;
- anger, indifference, aggressive behavior toward elder;
- history of substance abuse, mental illness, criminal behavior, or family violence;
- lack of affection toward elder;

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Reporting Recipient Abuse and  
Neglect

- flirtation or coyness as possible indicator of inappropriate sexual relationship;
- conflicting accounts of incidents;
- withholds affection; or
- talks of elder as a burden.

Signs of Financial Abuse

- frequent expensive gifts from elder to caregiver;
- elder's personal belongings, papers, credit cards missing;
- numerous unpaid bills;
- a recent will when elder seems incapable of writing will;
- caregiver's name added to bank account;
- elder unaware of monthly income;
- elder signs on loan;
- frequent checks made out to "cash";
- unusual activity in bank account;
- irregularities on tax return;
- elder unaware of reason for appointment with banker or attorney;
- caregiver's refusal to spend money on elder; or
- signatures on checks or legal documents that do not resemble elder's.

If you are aware of any of the above or suspect any of the above call APS/CPS immediately at:

**1-800-332-2272**

It is the responsibility of the APS workers to substantiate abuse/neglect/exploitation - not yours.

Refer to HCBS 399-3 for a questionnaire that can be used as a guideline for caregivers.

o o o





Department of Public Health  
and Human Services

## SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Principles of Charting

MECHANICS OF CHARTING--

1. All entries must be legible and in ink;
2. Errors are corrected by drawing a single line through the error, writing the word "error" above it, initialing it, and then writing the correct entry. NEVER erase, draw multiple lines through an error or use correction fluid;
3. Ditto marks should not be used;
4. Each page should have the recipient's name on it;
5. The full date of each entry must be recorded;
6. Each entry must end with the signature or initial of the person making the entry; and
7. Entries should be made in sequence. If it is necessary to make a late entry, indicate the date of the late entry and the date of the occurrence. For example, 07/30/96 charting for 07/28/96.

RULES OF CHARTING--

1. Do not sign entries of any kind for another person. It is permissible for one person to chart when both team members visit the recipient, but both team members should sign or initial the entry; and

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Principles of Charting

2. Do not chart before an event occurs.

CHART CONTENTS--

1. Record pertinent observations, psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;
2. Chart facts, what is seen, heard, felt and smelled. Make objective rather than subjective statements and avoid making generalizations, vague comments and opinions. For example, (objective statement) Less talkative than yesterday. Taking medications as prescribed. (Subjective) Quiet and cooperative.;
3. Record approaches to correcting problems identified in the recipient care plan;
4. Record all teaching efforts, including instruction given to the recipient's family;
5. Record an opening statement when a recipient is enrolled and a closing statement when a recipient is discharged from services; and
6. Record the type of contact; e.g., telephone call, office visit, home visit, etc., and specifically identify who made the contact.

o o o

Department of Public Health  
and Human Services

## SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Serious Occurrence Report

DEFINITION--Many of the recipients of our services are vulnerable to all sorts of abuse. Case managers are mandated by law to report any instances or suspected instances of abuse to APS or CPS. They are also required to complete a Serious Occurrence Report (SOR), DPHHS-MA-129, when a situation calls for it. A SOR must be completed anytime an individual's life, health, or safety have been put at risk.

PROCESS--SORs are not optional, they are mandatory. Failure to complete a SOR when the situation warrants one, will result in a point sheet. All SORs must be submitted to the Regional Program Officer.

DISTRIBUTION--Forward all copies to the Regional Program Officer who will respond appropriately. The RPO will return the white copy to the CMT, retain the yellow copy and forward the pink copy to DPHHS.

Circumstances Warranting a SOR--Following is a list of incidents necessitating a Serious Occurrence Report:

1. Suspected physical or verbal abuse;
2. Neglect of the recipient;
3. Sexual harassment;
4. Injuries requiring medical intervention;
5. An unsafe working environment; and
6. Any event which is reported to APS/CPS or Law Enforcement.



## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Serious Occurrence Report

Who is Mandated to Complete a SOR--All providers of personal assistance services, home health services, hospice services, and HCBS case management teams.

It is the responsibility of the case management team to inform all HCBS providers other than those listed above that any serious occurrence must be reported to the case management team, who will then complete the SOR.

Which Provider Reports What--All providers are mandated to report incidents that involve recipients or affect the provider agency's ability to deliver services. Providers should report only those incidents pertinent to their specific services. For example, a PA provider reports on issues revolving around the provision of the PA agency's services - both state plan and HCBS; a home health provider should report on issues pertaining to the home health agency's services; the HCBS case manager should report on incidents that relate to the provision of HCBS which are not reportable by either the PA or HH providers.

If a provider has concerns about another provider, they should report the incident to APS and also inform the Regional Program Officer.

o o o

## SERIOUS OCCURRENCE REPORT

PROGRAM \_\_\_\_\_ DATE: \_\_\_\_\_  
 RECIPIENT \_\_\_\_\_ MEDICAID ID # \_\_\_\_\_  
 REPORTER: \_\_\_\_\_

PROVIDER	INCIDENT (what occurred):
	EFFECT (What resulted from the condition):
	CAUSE (Why did it occur):
	ACTION: (Address cause):
Resolved:	Yes <input type="checkbox"/> No <input type="checkbox"/>

(Forward all copies to Regional Program Officer for completion.)

DPHHS	Comments: _____
	_____
	_____
	_____
	_____
<input type="checkbox"/> Reviewed <input type="checkbox"/> Memo <input type="checkbox"/> Training <input type="checkbox"/> Case Conference <input type="checkbox"/> Sanction	Regional Program Officer _____ Date: _____



RELEASE OF CONFIDENTIAL INFORMATION

CLIENT'S NAME: \_\_\_\_\_

SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

-----  
-----

I, \_\_\_\_\_, authorize the release of

medical information  
social information  
financial information

to \_\_\_\_\_.

I understand that any information obtained will be kept confidential and will be used only for purposes directly connected with the formation of a Plan of Care and only for the time period I am requesting enrollment in the Home and Community Services Program.

-----  
-----

Signature of client or legal representative signing in his/her behalf:

x \_\_\_\_\_ Date: \_\_\_\_\_





## DFS Policy Manual: Adult Protective Services Responding to the Referral

---

### **Investigation of Referrals**

The DFS social worker must respond to a report of alleged abuse, neglect, sexual abuse or exploitation of an aged person, disabled adult or person with a developmental disability. If a DFS social worker is not allowed entry to investigate, obtaining a court order to investigate should be considered. (See Section 401-8 of this manual for this process.)

The local DFS office must record all protective service referrals in the Adult Protective Service Log.

### **Abuse in Long-Term care Facility**

If an aged person is living in a long-term care facility, referral must be made to the long-term care ombudsman for investigation as soon as possible.

Long-term care facilities are facilities that provide skilled nursing care, intermediate nursing care, or personal care as defined in 50-5-101, MCA.

The referral to the Long Term Care Ombudsman (LTCO) can be made by phoning the toll free Senior Citizen's Hot Line, 1-800-332-2272, or in Helena, 444-4676 or write to the Long-Term Care Ombudsman, Office on Aging, P.O. Box 8005, Helena, Montana 59604, marked **confidential**.

### **Response Time**

Any referral of an aged person, disabled adult or developmentally disabled person who is alleged to be suffering from physical and/or mental injury or sexual abuse must be investigated promptly.

Other protective service referrals may be considered non-emergency. Examples of a non-emergency referral may be the inappropriate use of funds or verbal abuse of an elderly person.

### **Persons Contacted**

The client should be contacted regardless of his or her physical or mental capacity because the client is primary to any planned intervention. It may be necessary to contact guardians, relatives, or friends to enlist their aid or to obtain information for making an adequate investigation. The DFS social worker may need to contact other professionals or agencies for needed information.

## DFS Policy Manual: Adult Protective Services Responding to the Referral

---

<b>Release of Information</b>	<p>In cases where a DFS social worker seeks information from another professional or agency and the professional or agency will not release the information because it is confidential, the DFS social worker should obtain written consent signed by the client that authorizes the release of information to the DFS social worker. A court order may be necessary if the client refuses to sign a release and the information is vital to the investigation.</p>
<b>Home Visits</b>	<p>The initial contact should be in the client's place of residence with prior notification to the client when possible.</p> <p>After the initial contact, additional home visits and office visits may be required. Visits should be scheduled, as much as possible, at the client's convenience.</p>
<b>Results of the Investigation</b>	<p>The DFS social worker conducting the investigation must determine if the complaint is substantiated and if protective services are needed. An assessment of risk must be completed on each case using the DFS-501, <u>APS Risk Assessment</u>.</p>
<b>Risk Assessment</b>	<p>The decisions to assign a level of risk and to provide adult protective services are professional judgments by the DFS social worker and/or the DFS social worker supervisor. The risk assessment instrument is used to assist in making, not dictating, decisions.</p> <p>The DFS social worker must make written documentation that the referral is substantiated, unsubstantiated, or unfounded.</p> <ul style="list-style-type: none"><li>Investigation records will reflect the assessment of risk and indicate the reasons the case is substantiated, unsubstantiated, or unfounded. The DFS-502 <u>APS Investigative Summary</u> must be used for this purpose. The worksheets DFS-502(A) through DFS-502(E) can be used to support this assessment. This assessment must be completed as soon as possible but not later than 60 days from the date of the referral. Collateral information to support this assessment is recorded on the DFS-504 <u>APS Contact and Narrative Summary</u>.</li></ul>

## DFS Policy Manual: Adult Protective Services Responding to the Referral

---

- The assessment must be completed within 10 working days if the alleged perpetrator has been suspended from employment due to the allegation (see Section 403-1 of this manual).
- DFS social workers can use photographs and physician's reports to support assessment decisions. The process for gathering this type of evidence is found in Section 401-9 of this manual.
- A substantiated case must have a case plan that is recorded on the DFS-503 APS Case Plan.
- In substantiated cases the narrative must include identification of resolved and unresolved problems.
- If the determination is made that an older person or a person with developmental disabilities is at substantial risk of death or serious physical injury, emergency protective services should be considered. Section 401-10 of this manual covers emergency protective service procedures.

### Social Worker Reports in Substantiated Cases

Since the Elderly and Developmentally Disabled Abuse Prevention Act now makes the first conviction of abuse, neglect, sexual abuse or exploitation of an elderly person or person with developmental disabilities a misdemeanor, information on substantiated cases must be provided to the county attorney so that he/she may consider prosecution of the perpetrator. Procedures and information to be used to notify the county attorney shall be developed jointly by the DFS social worker and/or supervisor and the county attorney. The county attorney can review the APS log periodically if he/she wishes to see the type of referrals DFS is responding to.

If the referral appears to be a criminal act, the DFS worker should call the appropriate county attorney and law enforcement agency to conduct the investigation. The call must be followed by sending a copy of the Intake Report, DFS-500.



## DFS Policy Manual: Adult Protective Services Responding to the Referral

---

Information must be shared with County Attorney

The county attorney will use reports from the department to determine if prosecution is indicated, therefore, the following information should be shared:

- Adult Protective Services Log (periodically) DFS-110B or the DFS-500 Adult Intake Report
- DFS-502 APS Investigative Summary
- DFS-501 APS Risk Assessment Form
- DFS-503 APS Case Plan
- DFS -504 APS Contact and Narrative Summary (if collateral information pertinent to the case is recorded)

### Notice to Named Perpetrator

Notice of substantiation of abuse, neglect, sexual abuse or exploitation must be sent by the investigating social worker (or hand delivered, if necessary) to the person or persons named as the perpetrator(s). A copy of the notice must be in the file. The notice must state the following:

- the allegation, but not the name or identity of the person who made the referral;
- that the investigation substantiated abuse, neglect, sexual abuse or exploitation;
- the possible impact of substantiation on the person's ability to be licensed or work in certain fields; and
- the person's right to have the substantiated report reviewed if such a review is requested in writing within 30 days of the date of the notice letter.

Please see the **SAMPLE LETTER** at the end of this section. It is preferable that the letter be sent by **Certified Mail**.

## **DFS Policy Manual: Adult Protective Services Responding to the Referral**

---

### **Exceptions**

If the notice will place the client in danger, an exception may be approved by the CSWS following review by the supervisor and regional administrator in consultation with legal staff. Such exception will be noted in the case file.

Notification will not be sent in substantiated self neglect cases where the perpetrator is also the victim.

Notification will not be sent to perpetrators in those cases where a DFS social worker has been asked by the long term care ombudsman or the Department of Health and Environmental Sciences to investigate abuse, neglect, or exploitation in a long-term care facility. In such cases the report should be sent to the agency requesting the investigation.

Notification must be sent to the guardian of a disabled person, when DFS has named the disabled person as a perpetrator in a case of substantiated abuse, neglect, sexual abuse or exploitation.

### **DFS Investigation Not a Criminal Investigation**

DFS social worker's investigation and assessment of risk are done to determine the client's need for adult protective services and are not designed as a criminal investigation. DFS social worker's must exercise caution when conducting their investigation in regard to information gathered that could be used as evidence in a criminal case. The DFS social worker must carefully document the information outlined in the paragraph above and safeguard any supporting documentation so it can be turned over to the county attorney. Criminal investigation is done by police, sheriff's office or other appropriate law enforcement professionals.

### **Special Requirements Involving Persons with Developmental Disabilities**

When a DFS social worker has substantiated that a staff person or a person in the care of a provider of developmental disabilities services has abused, neglected, sexually abused or exploited an adult with developmental disabilities and makes a recommendation to the county attorney to consider prosecution of the perpetrator, an APS team must be convened to make a recommendation for or against the prosecution. See Section 402-1.

## DFS Policy Manual: Adult Protective Services Responding to the Referral

---

**APS Team** The APS team should be convened for this purpose within 15 working days from the day DFS recommended that prosecution be considered by the county attorney.

When an APS team meets to make a recommendation in a case involving an adult in the care of a provider of developmental disabilities services the team must include a representative from the Developmental Disabilities Division of the Department of Social and Rehabilitation Services and a provider not involved in the matter.

**Convening the Team** The department or county attorney determines which cases involving an adult with developmental disabilities the team may need to consider, except in those cases where the DFS social worker is recommending that the county attorney consider prosecution of the perpetrator under Section 52-3-825 MCA of the Montana Elder and Developmentally Disabled Abuse Prevention Act. Others involved with the alleged victim may request the team to meet, but the final determination of convening the team is the responsibility of the department and/or county attorney based on the facts of the case and the needs of the individual.

The requirement to convene an APS team to make a recommendation regarding prosecution does not apply if the DFS social worker has referred the case to the county attorney and law enforcement for criminal investigation and the county attorney and/or law enforcement have accepted responsibility for the case.

### **Appeal Process** Written Appeal

In cases where the department substantiates a report of abuse, neglect, sexual abuse or exploitation, the alleged perpetrator named in the record has a right to request that the department amend or make additions to the case record on the grounds that the information is incomplete or incorrect.

The alleged perpetrator making the request must:

1. Make a written request for departmental review of the record within 30 days of the date of the notice of substantiated abuse, neglect, or exploitation;



**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

---

2. State the reasons in writing why he/she believes the determination to be in error; and
3. Send or have the local DFS office forward the request for review to the DFS regional administrator of the DFS region where the records originated.

The regional administrator or his/her designee(s) will evaluate the information and determine whether to amend the record. The regional administrator will send the response to the person requesting the review and to the DFS social worker whose case record is being reviewed. The DFS social worker will file in the case record the person's request for review and the regional administrator's response.

If the person requesting the review is not satisfied with the regional administrator's response they may request a review by the director within 15 days of receiving the regional administrator's response. All correspondence regarding this request will also be filed in the case record.

- In cases where a perpetrator has been suspended from employment due to the DFS substantiation of abuse, neglect, sexual abuse or exploitation and has requested review by the regional administrator, the review and response should be completed within 10 working days whenever possible.
- Regional administrators may base their determinations on findings of the district court or upon previous determinations made regarding a request for amendments or additions to the record at issue.
- In those cases where the director is reviewing the case the director will not conduct an independent investigation. The director can review the relevant records and documentation and consult with individuals who may have relevant information.
- DFS must give the county attorney all information regarding changes made as a result of a review.



**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

---

<b>Informal Complaint Process</b>	Whenever there are public complaints about Department of Family Services staff the requirements of Section 103-2 of the DFS Administrative Manual must be followed.
<b>Failure to Report</b>	If the DFS social worker has reasonable evidence that a person who is required to report elder abuse or abuse of a developmentally disabled person, as listed in Section 401-6 of this manual, has willfully failed to report the incident, the name of that person plus the evidence must be provided to the county attorney who will determine if prosecution for failure to report is indicated.
<b>NOTE</b>	If prosecution is recommended, the APS team must be convened in accordance with 402-1.
<b>References</b>	Section 52-3-204, MCA Section 52-3-804, MCA Section 52-3-811, MCA Section 52-3-602 through 604, MCA Section 52-3-825, MCA Section 52-4-104, MCA Section 11.9.109, ARM Section 11.5.203, ARM Section 11.9.602, ARM Section 11.5.609, ARM

**DFS DFS Policy Manual: Adult Protective Services  
Releasing Case Record Information**

---

**Releasing Case  
Record  
Information**

All APS records concerning aged persons or adults with developmental disabilities must be kept confidential, but may be released, when requested, to the following:

- A physician who is caring for the elderly or developmentally disabled person;
- legal guardian or conservator of an alleged victim, if that person is not the alleged perpetrator and the identity of the reporter is protected;
- the person named in the report, if not legally incompetent;
- person engaged in research if the perpetrator was convicted and victims names are not released;
- APS team
- DFS or SRS employees when the information is necessary to provide services to the client;
- guardianship programs recognized by DFS;
- providers involved in a licensing dispute with DFS;
- providers of services to aged persons or persons with developmental disabilities, if deemed by DFS to be in the client's best interest; and
- a state agency that issues a license held by the alleged perpetrator.

Records must be released, upon request, to the following:

- county attorney or law enforcement in connection with an investigation;

## 401-7a

**DFS DFS Policy Manual: Adult Protective Services  
Releasing Case Record Information**

---

- court; or
- grand jury.

The DFS social worker and supervisor must determine what case record information may be shared. This determination will be based on the needs of the authorized requestor, listed above, to have information to serve the interests of the alleged victim and any potential harm that may occur if the records are released.

Disclosure of case record information may be prohibited or challenged by the county attorney if a criminal investigation or proceeding involving the alleged victim is in process.

**NOTE**

The above requirements for releasing case record information also apply to those disabled adults not covered under the Montana Elder and DD Abuse Act. (For definition of disabled see Section 401-5).

**Reference**

Section 52-3-813 MCA

## Tips for Caregivers: A Questionnaire

Providing care for an elderly or disabled adult requires a lot of patience, time, and love. All too often, caregivers run the risk of neglecting themselves, affecting their ability to provide adequate services. The following questionnaire can be used as a guideline for caregivers. Please give it to the recipient and/or family members for their use. Let them know that if they answer “yes” to one or more of the following questions, they might consider seeking professional help or turning to whatever support system you can develop for them:

- Are you getting enough rest?
- Are you neglecting your own health?
- Is constant surveillance required as part of your care tasks?
- Have you turned to drugs or alcohol or increased their intake to deal with stress?
- Have your feelings toward the older person become more negative?
- Is the older person physically or verbally abusive toward you?
- Does the older person need legal assistance with things like estates, trusts, or living wills, which may be beyond your knowledge?
- Does the older person need to be transported often?
- Are you overwhelmed because you are taking care of more than one person at a time?
- Are financial constraints interfering with your ability to follow medical advice?
- Are problems from your family’s history resurfacing and contributing to the problem?
- Does your spouse resent the amount of time you spend as a caregiver?
- Are you confused, fearful, or angry as a result of being a caregiver?
- Is your family communicating regarding the division of responsibilities?

*Adapted from “Taking Care of Aging Family Members: A Practical Guide” by Wendy Lustbader and Nancy R. Hooyman (New York: The Free Press, 1994). © 1994 by Wendy Lustbader and Nancy R. Hooyman. © 1986 by The Free Press.*





Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Medicaid Eligibility Require-  
ments

MEDICAID ELIGIBILITY--Applicants for Medicaid must meet the eligibility criteria for the appropriate assistance program.

ELIGIBILITY  
GROUPS:

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)--All persons who are included in a monthly grant under the AFDC Program.

SUPPLEMENTAL SECURITY INCOME (SSI)--Persons receiving and/or eligible for cash assistance from the Federal SSI Program on the basis of age, blindness or disability. The Social Security Administration determines eligibility for the SSI Program.

MEDICALLY NEEDY--Other persons who meet categorical requirements related to AFDC or SSI, but are not receiving cash benefits due to having income above Medicaid standards. These persons may be eligible or become eligible when incurred medical expenses reduce their income to the Medically Needy income level. Eligibility for the Medically Needy Program is established every month. (Refer to HCBS 414 for a discussion of Medically Needy Billing Procedures.)

QUALIFIED MEDICARE BENEFICIARY (OMB)-- Persons who are eligible for Part B Medicare and who are under 200% of the poverty level are eligible to have Medicaid pay their Medicare premium, deductible, and co-insurance amounts.

FINANCIAL  
ELIGIBILITY  
DETERMINATION:

All persons applying for Medicaid must meet an income and resource test. The Eligibility Staff in the County Human Services Office is responsible for determining initial and ongoing financial eligibility for Medicaid. All

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Medicaid Eligibility Requirements

questions related to the eligibility determination process for Medicaid should be referred to the appropriate county office. (Refer to Appendix 299-6 for a listing of the county offices.)

WAIVER OF DEEMING--Deeming means that the income and resources of a spouse or parent (for persons 18 years of age or younger) are considered as the income and resources of the individual in determining financial eligibility for Medicaid even though not actually contributed.

The requirement for deeming is waived when the recipient is eligible for the Home and Community Based Services Program. The waiver of deeming is effective when recipients are enrolled and receiving Home and Community Based Services.

TRANSFER OF Assets--If picking up an individual from the community, the Case Management Team must have the eligibility staff check long term care eligibility before enrolling in HCBS program.

o o o

Department of Public Health  
and Human Services

**SECTION:**

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Home and Community Based Services  
Eligibility Requirements

INDIVIDUALS TO BE SERVED--To be eligible for Home and Community Based Services, persons must meet all the following criteria:

1. Be Medicaid eligible;
2. Be elderly (65 years or older) or certified as physically disabled by the Social Security Administration (SSA);
3. Be determined appropriate for the HCBS Program via a PASARR screen if the individual has a mental illness, mental retardation or a related condition;
4. Require the level of care of a nursing facility;
5. Not reside in a hospital or nursing facility; and
6. Be served in the community at costs that do not exceed the maximum plan of care limit;

o o o





Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Developmentally Disabled

DEFINITION USED BY THE DEPARTMENT--"Developmentally Disabled" means a person who is suffering from disabilities attributable to mental retardation, cerebral palsy, epilepsy, autism, or any other neurologically handicapping condition closely related to mental retardation and requiring treatment similar to that required by mentally retarded persons if the disability originated before the person attained age 18, has continued or can be expected to continue indefinitely and constitutes a substantial handicap of such persons.

SUBSTANTIALLY HANDICAPPED PERSON--Means a person who needs direct assistance in activities of daily living such as, but not limited to: eating, dressing, bathing, planning and preparing meals, shopping, planning for leisure time activities, caring for place of residence, and money management due to the developmental disability.

DEVELOPMENTALLY DISABLED WAIVER--HCFA approved a separate waiver to provide Home and Community Based Services to persons determined to be developmentally disabled in accordance with the definitions above and who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

ADMINISTRATIVE RESPONSIBILITY--The Department's Disability Services Division is responsible for administering the waiver program for individuals with developmental disabilities. The Disability Services Division is responsible for such functions as establishing waiver services, participating in prescreening, developing and approving plans of care, negotiating reimbursement rates and monitoring the delivery of services.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Developmentally Disabled

SERVING DEVELOPMENTALLY DISABLED UNDER THE HOME AND COMMUNITY BASED SERVICES WAIVER--To serve developmentally disabled persons under the Home and Community Based Services Waiver, persons must meet all waiver eligibility criteria including SSA certification of disability and level of care criteria.

o o o

Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Care Categories

DEFINITION--Care categories are mechanisms for tracking Home and Community Based Services (HCBS) Program costs for federal reports. Recipients in the HCBS Program fall into three distinct categories:

CC1: Individuals over the age of 65.

CC2: Individuals who are SSA disabled under the age of 65.

CC3: Individuals entering the Bridges or Headway programs, individuals who are ventilator dependent, and individuals in supported living.

PLAN OF CARE COST LIMIT--The Plan of Care cost limit for Care Category 3 should not exceed what the Medicaid payment for that person would have been in an inpatient hospital or rehabilitation setting.

PROGRAM ELIGIBILITY--The Department will determine eligibility for enrollment of Care Category 3 due to the high cost of services and the limited number of slots. These slots will be allocated by the Community Services Bureau to Case Management Teams via the Regional Program Officer upon request when a recipient has been determined to be eligible for CC3.

REFERRAL PROCEDURES FOR CC3 RECIPIENTS--

RESPONSIBILITY	ACTION
Mountain Pacific Quality Health Foundation:	<ol style="list-style-type: none"> <li>1. Screens individual to determine level of care.</li> <li>2. Refers individual to Case Management Team if individual meets level of care.</li> </ol>



SECTION:

ELIGIBILITY FOR SERVICES

SUBJECT:

Care Categories

Case Management

- Team (CMT)
3. Develops Plan of Care (DPHHS-MA-135) and Cost Sheet (DPHHS-MA-134).
  4. Completes Request for Prior Authorization for CC3 (Ventilator Dependent, TBI-Bridges/Headway, Supported Living clients), DPHHS-MA-148. (Refer to Appendix 899-21.)
  5. Submits to the Regional Program Officer: Plan of Care, Cost Sheet, Intake Sheet, and Prior Authorization for CC3.

Regional Program

- Officer (RPO)
6. Reviews Plan of Care documents.
  7. Signs Request for Prior Authorization for CC3 and Intake Sheet.
  8. Submits referral package containing all documents to the Community Services Bureau for initial ventilator dependent and supported living slots.

Community Services

- Bureau
9. Approves or denies request.
  10. Notifies RPO by completing the bottom section of the Request for Prior Authorization for CC3.

Regional Program

- Officer
11. If denied, notifies applicant/recipient via the Letter of Notification, DPHHS-MA-144. (Refer to Appendix 899-18.)

o o o

Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Recipient Identification

GENERAL RULE--Each recipient eligible for Medicaid is assigned a unique 10 digit Medicaid Identification Number which is their Social Security Number plus one check digit.

MEDICAID IDENTIFICATION CARD--Each month the Department issues an identification card or a letter verifying eligibility to each recipient determined to be eligible for Medicaid benefits. The identification card covers eligibility for only one month, so it is important for providers to check the card to be sure it covers the current month. (Refer to Appendix 499-1 for an example of the Medicaid Identification Card.)

ELIGIBILITY INFORMATION--The County Office of Human Service determines Medicaid eligibility and should be contacted if there is a question about a person's eligibility for Medicaid. (Refer to Appendix 299-6 for a list of County Office of Human Services.) Many of the county offices require eligibility inquiries to be submitted in writing. For those counties, inquiries should be made on the SRS-MA/FA 456, "Provider Inquiry of Medicaid/State Medical Eligibility." (Refer to Appendix 499-3.) These forms are available from Consultec. Eligibility may also be verified through Voice Response at Consultec, 800-714-0060.

HCBS DEPRIVATION CODES--Claims for HCBS procedures will be paid only if the recipient has a HCBS deprivation code on the Medicaid Management Information System (MMIS). Deprivation codes are "WA" for persons who are elderly and "WD" for persons who are disabled. These codes are entered on MMIS after the county Eligibility Specialist is notified of HCBS enrollment by the Case Management Team. Notification of HCBS enrollment is made on Form DPHHS-DD/MA-055. (Refer to Appendix 899-6.)

o o o



Department of Public Health  
and Human Services

**SECTION:**

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Restricted Card Program

PROGRAM DESCRIPTION--When utilization of Medicaid services is excessive, inappropriate, or fraudulent, recipients are restricted (locked-in) to designated providers and/or required to obtain Department approval prior to receiving non-emergency services. The most commonly restricted services are physician, pharmacy and dental.

IDENTIFICATION CARD--The Department issues special Medicaid Identification Cards that identify restricted recipients. Recipients and providers have joint responsibility for exchanging information contained on the restricted card. Information on lock-in requirements specific to a recipient may be obtained from the County Office of Human Services.

PROVIDER LOCK-IN--When a restricted recipient is locked-in to designated primary providers, Medicaid payment for non-emergency services will only be made to the providers listed on the restricted card (refer to Appendix 499-2). All other providers, including hospitals, are at risk of being denied Medicaid payment unless a referral was made by the primary provider or services were for a bona fide emergency. Restricted recipients are responsible for payment of unauthorized services.

PRIOR AUTHORIZATION--Some restricted recipients need non-emergency Medicaid services authorized by the Department before receiving services. In these cases, providers must call the Surveillance/Utilization Review Unit to assure Medicaid payment for non-emergency medical or drug services.

o o o





Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Copayments

Reference: ARM 46.12.204

GENERAL RULE--The federal government allows states to require certain recipients to share in the costs of Medicaid by imposing copayments. A provider cannot deny services to an eligible recipient solely because the recipient is unable to pay the copayment.

COPAYMENT REQUIREMENTS--On September 1, 1983, Montana implemented copayments on selected service areas. Copayments apply to both categorically and medically needy recipients. (Refer to Appendix 299-7 for a list of those services requiring copayment.)

COPAYMENT EXEMPTIONS--Home and Community Based Services (HCBS) are exempt from copayment, but persons enrolled in the HCBS Program are responsible for copayments on other State Plan Medicaid services.

The following recipients are also exempt from all copayments:

- Individuals under 21 years of age;
- Pregnant women;
- Inpatients in a medical institution who are required to spend a portion of their income on the cost of care (persons in nursing facilities);
- Individuals receiving emergency or family planning services; and
- Individuals receiving hospice services.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Copayments

COPAYMENT LIMITS--The total copayment for each Medicaid case shall not exceed 5% of the maximum yearly AFDC grant for one adult. The maximum shall be based on the AFDC grant in effect at the end of the state fiscal year.

o o o

Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Freedom of Choice

GENERAL RULE--Federal regulations mandate that if an individual meets level of care requirements for long-term care, the individual or his legal representative must be:

1. informed of feasible alternatives available under the Home and Community Based Services Program; and
2. given the choice of either institutional or Home and Community Based Services.

FREEDOM OF CHOICE OF PROVIDERS--Individuals have the right to choose among qualified providers.

o o o





Department of Public Health  
and Human Services

HOME AND COMMUNITY BASED  
SERVICES

SECTION:

ELIGIBILITY FOR SERVICES

SUBJECT:

Private Pay

GENERAL RULE--Home and Community Based Services are available to persons who choose to pay privately for the services. These persons are not Medicaid eligible.

PROCEDURES--The case management team develops its own policies and procedures for serving private pay individuals.

FEE SCHEDULE--Fees for private pay persons are established by the case management team. Private pay fees must not be less than what Medicaid recipients are charged for the same service.

o o o



Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Prior Authorization

DEFINITION--Prior authorization means approval to exceed limits for payment of certain services before they are rendered.

REQUIREMENT--The Case Management Team (CMT) must request prior authorization when the recipient requires services in excess of program limits for:

1. Care Category 3 Plans (Refer to HCBS 404);
2. Cognitive Rehabilitation (Refer to HCBS 508);
3. Environmental Accessibility Adaptations in excess of \$8000 (Refer to HCBS 513);
4. Exceptions to maximum Plan of Care cost limit (Refer to page 2 and 3);
5. Respite, when provided in a hospital (Refer to HCBS 526); or
6. Specialized Medical Equipment or Supplies in excess of \$5000 (Refer to HCBS 528).

PROCEDURE--All requests for prior authorization of excess services must be made on the Request for Prior Authorization (Form DPHHS-MA-149, refer to Appendix 899-22.) Authorization for provision of excess services or over cost plans of care is delegated to the Regional Program Officer (RPO). The CMT must forward the Request for Prior Authorization Form to the RPO. If the RPO concurs, the RPO will sign and return the request to the CMT. If the RPO does not concur, the reasons for non-concurrence will be documented on the Request for Prior Authorization. Requests for exceptions to the maximum plan of care cost limit



## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Prior Authorization

should include a copy of the proposed Plan of Care and Plan of Care Cost Sheet. The DPHHS-MA-149 "Narrative and Justification" section must provide detailed information regarding the recipient's need for excess services.

AUTHORIZATION FOR EXCESS SERVICES--The responsibility for approving requests for excess cognitive rehabilitation, environmental modifications and specialized medical equipment and supplies is delegated to the RPO who will consider the following:

1. Provision of excess services can be made while staying within the plan of care cost limit.
2. Whether any State Plan services could be used as an alternative.
3. Whether all other options have been exhausted.

AUTHORIZATION OF OVER COST--The RPO is responsible for reviewing and approving requests for costs over the plan of care cost limit. Authorization for over cost will be made by considering the following criteria:

1. The service making the recipient exceed costs is a one-time purchase, e.g., specialized medical equipment or environmental modification.
2. Adult residential care recipients whose needs are extensive and whose costs exceed the limit.
3. Intensive services for 90 days or less:
  - a. to resolve a crisis situation which threatens the health and safety of the individual;

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Prior Authorization

- b. to stabilize the individual following hospitalization or an acute medical episode; and
- c. to prevent institutionalization during the absence of the normal caregiver.

The Home and Community Based Services Program is not an entitlement program. It is important for the CMT to arrange for services within the plan of care cost limit to keep the program from exceeding federal and state funding authorities.

o o o



Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Termination of Services

The Department will provide written notice to applicants and recipients at least ten working days before the date of an adverse action.

The Letter of Notification, form DPHHS-MA-144, (Refer to HCBS 899-18) shall be used to provide notification of adverse action for all reasons except terminations and denials based on level of care for which the Mountain-Pacific Quality Health Foundation completes the DPHHS-MA-61 (Refer to HCBS 799-1). The DPHHS-MA-144 and DPHHS-MA-61 tell the recipient how to request a fair hearing (Refer to HCBS 302). The Case Management Team (CMT) or Regional Program Officer (RPO) must mail the notice at least ten working days before the date of the action.

REQUIREMENT--Written notice of adverse action is required when Home and Community Based Services (HCBS) are denied or terminated for any of the following reasons:

1. The recipient no longer meets level of care requirements. In this instance, the Foundation notifies the individual via DPHHS-MA-61;
2. The plan of care costs exceed the maximum limit. The RPO notifies the individual via DPHHS-MA-144;
3. The recipient is no longer eligible for Medicaid. In this case, the local Eligibility Staff mails a notice; and
4. Termination of HCBS for other reasons. In this instance, the CMT completes the DPHHS-MA-144 with concurrence from the RPO and indicates reasons for termination.



## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Termination of Services

EXCEPTIONS FROM ADVANCE NOTICE--Terminations for the reasons listed below do not require advance notice:

1. The recipient is admitted to a nursing facility, hospital or intermediate care facility for the mentally retarded (ICF/MR); or
2. The recipient requests in writing that services be terminated or refuses to sign the plan of care.

TERMINATION DUE TO LACK OF PROGRAM FUNDS--The Department will provide at least 30 days notice before any termination of services due to insufficient program funds.

DEATH--The effective date of HCBS discharge is the date of death.

ADMISSION TO A NURSING FACILITY, TRANSITIONAL CARE UNIT (TCU), ICF-MR--If the recipient is admitted to a nursing facility, transitional care unit, or ICF-MR, the recipient must be discharged from the Home and Community Based Services (HCBS) program effective the day of admission to the facility. If the recipient is an inpatient in a hospital prior to the nursing facility admission, the effective date of HCBS discharge is the first day of hospitalization.

A CMT may elect to hold the slot open and reenroll the recipient at a later date. The Department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed for those days. (Refer to reenrollment process in this section on page 4.)

Refer to HCBS 417 for exceptions to this policy.

ADMISSION TO A HOSPITAL--If a recipient is admitted to a hospital, no payment for HCBS can be made during the recipient's hospitalization

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Termination of Services

period except that it is permissible for the team to bill for case management and other services provided on the day of hospital admission and the day of hospital discharge if the recipient returns to HCBS. (Refer to HCBS 417 for exceptions to this policy.) If the recipient remains in the hospital for more than 30 days, the CMT must discharge the recipient from HCBS. The discharge date should be the date of admission to the hospital.

Services (e.g., home modification, homemaker) that need to be provided to assist the recipient to return home can be arranged and completed prior to the recipient's discharge from the hospital; but must not be billed until the recipient returns home. HCFA has determined the discharge date to be the date services become available to the recipient.

If the recipient is unable to return to his residence (e.g., death or alternate placement), payment for services provided prior to hospital discharge can be reimbursed by Medicaid. However, the CMT must have completed a Plan of Care form (DPHHS-MA 135) or Plan of Care Short form (DPHHS-MA-135-B) prior to the commencement of such services for reimbursement to be approved.

TEMPORARY ABSENCES:--The recipient can be temporarily absent from home for up to 30 days for vacations, visits, and to receive outpatient medical care and continue to receive HCBS. In order for the CMT to bill during a period of temporary absence, the following conditions must be met:

1. There must be a plan for the recipient to return home; and
2. The record must document that case management continued to be provided during the recipient's absence (e.g., telephone contacts to check on the recipient's progress, etc.).

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Termination of Services

tacts to check on the recipient's progress, etc.).

If the recipient does not return within 30 days, the recipient must be discharged from HCBS.

Refer to HCBS 417 regarding payment for other HCBS services.

EXTENDED ABSENCE--Occasionally a recipient may require an absence of more than 30 days but still plan to return to HCBS. The CMT may elect to hold the slot open and re-enroll the recipient upon return. The department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed in these instances.

DISCHARGE PROCEDURE--The CMT must do discharge planning for recipients who will be terminated from services and complete the Discharge Sheet, Form DPHHS-MA-137 (Refer to HCBS 899-13). A discharge notification must be sent to all appropriate individuals involved in the case including the health care professional, and service providers. The CMT must send a DPHHS-DD/MA-55 form to the Eligibility Staff (Refer to Appendix 899-6).

RE-ENROLLMENT--If an individual has been discharged from HCBS services for a short term hospital or nursing facility stay or extended absence and the CMT is holding the individual's slot open, the CMT need not complete a new plan of care unless a change in the individual's condition warrants it. An Intake Sheet (DPHHS MA-136) must be sent to the Department, a DPHHS-DD/MA-55 form sent to the county, and a Level of Care Determination form (DPHHS-MA-86) sent to the Foundation.

o o o



Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Referrals for Service

REQUIREMENT--Referrals for Home and Community Based Services (HCBS) should be directed to the Case Management Team (CMT) serving the county where the individual resides or the Mountain Pacific Quality Health Foundation. Referrals for HCBS may come from any source.

If the individual being referred is not currently eligible for Medicaid, the CMT should refer the individual to the county Eligibility Staff for a determination of Medicaid eligibility.

GENERAL INQUIRIES--The CMT must respond to or follow up on general inquiries regarding HCBS within ten working days.

REFERRAL FORM--Formal referrals from Department staff or the Foundation to the CMT will be submitted in writing or verbally. Verbal referrals must be identified as formal referrals if they are to be acted upon.

RESPONSE TIME--The CMT must initiate contact within three working days of receipt of a formal referral. Onsite visits must be made within 60 days of referral.

REFERRAL SUMMARY--The case record progress notes should begin with a summary of the initial contact, including who made the referral, the date the referral was received, the date and name of the team member making the initial contact, who was contacted and how the initial contact was made; i.e., telephone, office visit, home visit, etc.

MODE OF RESPONSE-- The initial contact may be either in person or by telephone. When the first contact is a phone contact, the in-person visit should follow as soon as possible not to exceed 60 days from date of initial referral.

o o o





Department of Public Health  
and Human Services

**SECTION:**

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Waiting List Criteria

ENROLLMENT--Until all slots are filled, enrollment for elderly and physically disabled individuals will be on a first come-first serve basis. All open slots must be equally available to all eligible individuals in the Case Management Team's (CMT) service area. CMTs serving more than one county must not allocate slots per county.

WAITING LIST CRITERIA--When all slots are filled, a waiting list must be established by the CMT to select individuals most in need of services. Individuals placed on the waiting list must be assessed in person within 60 days of the date of the formal referral. Priority is established by considering the criteria on the Waiting List Criteria Tool (DPHHS-MA-146). A Waiting List Criteria Tool will be filled out for each individual awaiting HCBS. (Refer to Appendix 899-20.)

REVIEW OF WAITING LIST--The CMT will determine when review of an individual on the waiting list is necessary. Review consists of verifying the individual's current eligibility and need for service. If the individual's level of care or need for services is questionable, the CMT may involve the Mountain Pacific Quality Health Foundation through a phone consultation.

If the individual being reviewed continues to qualify, it is not necessary for the Foundation to complete new screening tools or to send a DPHHS-MA-61. The CMT will enter the review information in the individual's record.

If the individual being reviewed does not meet level of care, the Foundation will notify the individual with a DPHHS-MA-61, with a copy to the CMT.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Waiting List Criteria

Any individual on the waiting list over 60 days and being considered for HCBS placement will require a new level of care decision from the Foundation.

WAITING LIST DATABASE--Case Management Teams are required by the department to maintain an electronic waiting list which can be uploaded upon request. The database allows both the teams and the department to access information about the waiting list. Refer to Appendix HCBS 899-25 for instructions on entering data.

o o o

Department of Public Health and Human Services	SECTION:  ELIGIBILITY FOR SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Medically Needy Billing Procedures

DEFINITION--Medically needy means aged, blind, or disabled individuals or families and children who are otherwise eligible for medicaid and whose income is above the prescribed limits for the categorically needy but within the limits set forth by Social Security Administration.

#### MEDICALLY NEEDED BILLING PROCEDURES

RESPONSIBILITY	ACTION
Eligibility Specialist	1. Notify the recipient and Case Management Team (CMT) of the amount of incurment.
Case Management Team (CMT)	2. The case management charge will be used before other HCBS services toward the incurment. The CMT must prepare and provide a bill for case management services to Eligibility Specialist. This bill must contain the CMT's provider number.
Eligibility Specialist	3. If the case management bill is less than the incurment amount, other services provided under the Home and Community Based Services (HCBS) Program can be used to meet the person's incurment amount. The Specialist will contact the CMT for information regarding other HCBS expenses.  4. Notify the applicant and CMT of eligibility dates.  5. Issue the Provider Information Memo (SRS-FA 454) if appropriate. (Refer to Appendix 499-4).



SECTION:

ELIGIBILITY FOR SERVICES

SUBJECT:

Medically Needy Billing  
Procedures

Case Management  
Team

6. Collects payment for case management from the recipient.

o o o

Department of Public Health  
and Human Services

**SECTION:**

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Residency Requirements

REQUIREMENT--In order to be eligible for Home and Community Based Services (HCBS), the recipient must reside in their own home which can include a foster home, personal care home, or group home.

HCBS are not available to recipients who are inpatients of a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

o o o



Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Out-of-State Services

A HCBS recipient may receive HCBS services out of state on a temporary basis. These services can be provided under three options:

1. The recipient may utilize their Montana provider. This means they would be taking their current personal assistant, habilitation aide, or homemaker with them. In this instance, we only pay for service time, not mileage or per diem. It is up to the provider agency to authorize the caretaker's travel.
2. The case management team may utilize an out-of-state provider. The CMT would have to find a provider of the specific service required. The provider must enroll with Consultec and be approved by the CMT. The out-of-state provider must also accept our HCBS rate and meet our service requirements. To locate a provider in another state, contact that state's Medicaid agency. You can find them on the Internet.
3. The CMT may utilize an out-of-state provider but bill for HCBS services following instructions in section HCBS 605.

o o o





Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Bed-Hold Days

Effective 4/01/01

DEFINITION--Bed hold days are those days on which a provider may still be reimbursed for services even though the HCBS recipient is absent from the home or adult residential care facility. The recipient may be in a hospital, nursing facility, or visiting friends or relatives for this period of time. Bed-hold days may not exceed 30 days or 720 hours per plan of care year per recipient.

AFFECTED SERVICES--This policy pertains only to the following services:

1. Adult Day;
2. Adult Residential;
3. Case Management;
4. Personal Assistance Services;
5. Private Duty Nursing;
6. Residential Habilitation;
7. Specially Trained Attendants; and
8. Supported Living.

REQUIREMENT--A provider may be paid only if an agreement has been made with the CMT to allow for reimbursement during these absences. The purpose of allowing reimbursement is to ensure the provider will be available to the recipient on their return to HCBS. Reimbursement for Private Duty Nursing, Adult Day, or Personal Assistance Services will not be made if the nurse, adult day facility, STA or personal assistance attendant, etc., can provide services to another recipient during that time period.

The case management team must keep a record of a recipient's absenteeism to ensure that it does not exceed 30 days or 720 hours. They should also have agreements in place with providers to ensure they understand payment will not be made

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Bed Hold Days

in excess of the 30 days or 720 hours. If bed-hold days exceed 30 days or 720 hours and the providers were not notified of this policy, CMTs will be responsible for payment to effected providers.

PROCEDURE--If a recipient is absent under this policy, the CMT should **not** send a Discharge Sheet (DPHHS-MA-137) to the Department, nor should an Entrance/Discharge Into Medicaid Home and Community Based Services (DPHHS-DD/MA-55) be sent to the county.

o o o

# IV MEDICAID ELIGIBILITY

IV - 5

## SAMPLE - MEDICAID ID CARD - FRONT

99/99/99 99999 \*\*\*\*\*9.99 99999 9999999999

\*\*\*\*\*9.99

Last Name, First Name MI

Street Address

Street Address

City, State Zip Code

### MEDICAID IDENTIFICATION CARD - PUBLIC HEALTH & HUMAN SERVICES

PERIOD VALID MAY 1 TO MAY 31, 1996 YELLOWSTONE

NAME	MEDICAID#	BIRTHDATE	SX	QMB	INS	MEDICARE
------	-----------	-----------	----	-----	-----	----------

DOE, JANE	551111222	01/01/73	F	N		
BASIC HMO: YELLOWSTONE COMMUNITY HEALTH (406) 222-9999						

DOE, JOSEPH	111221331	01/02/92	M	N		
FULL MANAGED CARE: PENDING						

DOE, JOHN	211188777	01/04/55	M	N		
BASIC MANAGED CARE: EXEMPT						

DOE, JIM	333118877	01/04/90	M	N		
FULL PASSPORT PROVIDER: DR. JOHN JONES PHONE: (406)444-1111						

### TPL INFORMATION

1. xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxx xxxxxxxx, xxxxxxxx x  
999-99-9999
2. xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxx xxxxxxxx, xxxxxxxx x  
999-99-9999
3. xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxx xxxxxxxx, xxxxxxxx x  
999-99-9999

### RESTRICTED INFORMATION

XX  
XX  
XX



# IV MEDICAID ELIGIBILITY

## SAMPLE - MEDICAID ID CARD - BACK

### WARRANT AREA

#### GENERAL MEDICAID INFORMATION:

**1-800-362-8312**

#### INFORMATION FOR CLIENTS

REFER TO YOUR HANDBOOK OR MEDICAID BROCHURE FOR ADDITIONAL INFORMATION OR EXCEPTIONS

Please remember that Medicaid will pay for ONLY medically necessary and appropriate services. Most Medicaid services have limitations. Check with the General Medicaid Information line to see if a service is covered under Medicaid. If you have further questions, ask the County Welfare Office or Office of Human Services for a Medicaid brochure. If you have "Restricted To" under your name, you are required to get all services from that provider, unless there is a referral to another provider. If you have "Prior Authorization" under your name, you are required to get prior authorization from Medicaid for all services. If you have the word BASIC under your name, some Medicaid services are not available to you. See the chart below to find out if a particular Medicaid service is available to you. NOTE: Medicaid may require that you pay a copayment, ranging from \$ .50 to \$100.00.

#### RIGHT TO APPEAL

You have the right to a fair hearing when a medical service you receive is denied payment. Please call the MEDICAID INFORMATION LINE, 1-800-362-8312, or write to P.O. Box 4210 Helena MT 59604 if you want to appeal a denial.

#### HEALTH INSURANCE

Notify your Eligibility Specialist of any changes in your private health insurance coverage.

SERVICE	SERVICE INCLUDED IN BASIC PLAN	NEED DRUG PROVIDER APPROVAL	NEED PASPORT PROVIDER APPROVAL
Ambulance	Yes	Yes	No
Birth Control	Yes	No	No
Dental/Dentures	NO	No	No
Doctor/Chad	Yes	Yes	Yes, except for birth control, pregnancy related service or need immunizations
Drugs	Yes	No	No
Emergency Room	Yes	Yes	Yes, unless life threatening
Eye Exam	NO	No	No
Eye Glasses	NO	No	No
Hearing Aids and Audiology	NO	No	No
Home Health	Yes	Yes	No
Hospital Inpatient	Yes	Yes	Yes, except for birthing baby delivered
Hospital Outpatient	Yes	Yes	Yes
Mental Health	Yes	No	No
Personal Care Attendant	NO	No	No
Prosthes	Yes	Yes	No
Physical, Occupational, Speech Therapy	Yes	Yes	No
Supplies & Equipment	NO	No	No

SHOW YOUR CARD

SHOW YOUR CARD

SHOW YOUR CARD

## **IV MEDICAID ELIGIBILITY**

IV - 9

### **K. RESTRICTED CARD PROGRAM**

When a recipient's utilization of Medicaid services is excessive, inappropriate, or fraudulent, a recipient is restricted (**LOCKED-IN**) to designated, primary providers. The most common restriction is to a single physician and pharmacy.

When a recipient is on prior authorization restriction, a provider must call the Department's Surveillance/Utilization Review (SUR) Unit to assure Medicaid payment for non-emergency medical or pharmacy services, Monday through Friday, 8:00 to 5:00 at 444-4168. Only true emergency services will be assured payment after hours and on weekends.

Non-emergency services are those which do not meet the following definition of emergency. "Emergency services are necessary treatment of accidental injury which require immediate attention or treatment of a life threatening medical condition."

Please see the following examples of the Medicaid ID card messages indicating Restricted Recipients and Prior Authorization Recipients.

#### **EXAMPLE ID CARD: RESTRICTED MESSAGE**

"JANE DOE IS RESTRICTED TO: J.F.SMITH, M.D.; Rx PHARMACY; AND L.S. TOOTH, DDS. MEDICAID PAYMENT WILL NOT BE MADE TO OTHER PHYSICIANS, PHARMACIES, DENTISTS, OR HOSPITAL EMERGENCY ROOMS EXCEPT FOR ACCIDENTS REQUIRING IMMEDIATE ATTENTION, LIFE THREATENING PROBLEMS OR REFERRAL BY THE ABOVE NAMED PHYSICIAN."

#### **EXAMPLE ID CARD: PRIOR AUTHORIZATION MESSAGE**

"JOHN DOE IS RESTRICTED. PRIOR AUTHORIZATION IS REQUIRED FOR ALL NON-EMERGENCY MEDICAL AND PHARMACY SERVICES. FOR PRIOR AUTHORIZATION CALL SUR UNIT AT 444-4168. SERVICES FOR EMERGENCY ROOM VISITS WILL BE PAID ONLY IF THEY ARE FOR ACCIDENTS REQUIRING IMMEDIATE ATTENTION OR LIFE THREATENING PROBLEMS."

The restricted recipient's Medicaid ID Card alerts all providers to the restriction. RECIPIENTS AND PROVIDERS HAVE JOINT RESPONSIBILITY FOR EXCHANGE OF INFORMATION CONTAINED ON THE MEDICAID IDENTIFICATION CARD. However, assistance on lock-in requirements specific to a recipient may be obtained by calling the SUR Unit at 444-4168.



**PROVIDER INQUIRY OF MEDICAID/STATE MEDICAL ELIGIBILITY**

**Instructions:** Please complete the provider section of this form, sign and date, attach the applicable Statement of Remittance, and send to the client's welfare office. If you do not receive a response within ten days refer to your Medicaid Management Information System Provider Manual, Recipient Eligibility Section, for the county contact person. If you need more provider inquiry forms, please contact Consultec for reordering.

<b>Provider:</b> _____ Address: _____ City: _____	Provider ID Number: _____ Provider Phone Number: _____ Date of Inquiry: _____
<b>Patient:</b> Name: _____ ID #: _____ Date of Birth: _____ Date of Service: _____	<b>Parent or Guardian:</b> (if patient is a minor) Name: _____ ID #: _____ Address: _____ City: _____

**Information Being Requested:**

Please attach a copy of the Statement of Remittance. Highlight the line in question.

Signature of Requestor

Date

**County Response:****Dates of Eligibility:** \_\_\_\_\_

Signature of County Respondent

Title

Date

Distribution: Initial Request  
 Provider - Pink  
 County Office - Canary & White

County Response  
 County - Canary  
 Provider - White





STATE OF MONTANA  
Department of Public Health and Human Services  
MEDICAID PROGRAM

# Provider Informational Memo



## Medicaid Incurment

Provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider ID:

\_\_\_\_\_

Recipient:

\_\_\_\_\_

(Name)

Birthdate: \_\_\_\_\_ ID#: \_\_\_\_\_

Recipient

Responsibility:

The recipient is responsible for \$ \_\_\_\_\_ of the charge for the

service(s) provided on \_\_\_\_\_  
(Date)

The balance of the charge will be paid up to the Medicaid rate.

Eligibility

Period:

The recipient will be Medicaid eligible from

\_\_\_\_\_ to \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

Prepared by: \_\_\_\_\_ Date: \_\_\_\_\_

County: \_\_\_\_\_

Distribution:

White - Provider

Yellow - Case File



Department of Public Health  
and Human Services

## SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Service Requirements

COVERED SERVICES--The following services, provided under the Home and Community Based Services (HCBS) Program, are included in the HCBS proposal:

1. Adult Day Health
2. Adult Residential Care
3. Behavioral Programming
4. Case Management
5. Chemical Dependency Counseling
6. Cognitive Rehabilitation
7. Community Residential Rehabilitation
8. Comprehensive Day Treatment
9. Consumer/Family Intensive Support Service
10. Day Habilitation
11. Dietitian
12. Environmental Accessibility Adaptations
13. Habilitation
14. Homemaker
15. Nutrition/Meals
16. Occupational Therapy
17. Personal Assistance Service
18. Personal Emergency Response System
19. Physical Therapy
20. Prevocational Training
21. Private Duty Nursing
22. Psychosocial Consultation
23. Registered Nurse Supervision
24. Residential Habilitation
25. Respiratory Therapy
26. Respite Care
27. Special Child Care for Children with AIDS
28. Specialized Medical Equipment & Supplies
29. Specialized Trained Attendants
30. Speech Therapy and Audiology
31. Supported Employment
32. Supported Living
33. Transportation



## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Service Requirements

ADDITIONAL SERVICES--Any additional HCBS services added to the program must be requested by the Department and approved by HCFA. The criteria for approval of additional services is cost-effectiveness and that the services are necessary to avoid institutionalization.

o o o

Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Service Limitations and  
Exclusions

ROOM AND BOARD--Federal regulations specifically exclude all payment for room and board services under the Home and Community Based Services Program except when provided as part of respite care. HCFA defines "board" as three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services. "Room" means hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services.

CASE MANAGEMENT--An individual receiving case management services under the Home and Community Based Services Program may not also receive case management services funded through another Medicaid program.

o o o



Department of Public Health  
and Human Services

SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Adult Day Health

DEFINITION--Adult Day Health provides a broad range of health, nutritional, recreational, social and habilitation services in settings outside the person's place of residence. Adult Day Health services do not include residential overnight services.

SERVICE REQUIREMENTS--Adult Day Health providers must meet the following criteria:

1. Be licensed by the Department of Public Health and Human Services.
2. If personal assistance services are provided as a part of adult day health, these services must be supervised by a registered nurse or licensed practical nurse.

SERVICES OFFERED BY THE ADULT DAY HEALTH CENTER--The adult day health center must provide at least one meal a day to recipients who stay at the center four hours or more. The center must also have a written agreement with each recipient or other person responsible for the recipient that pertains to cost of care, type of care, services to be provided and the manner by which the responsible party will be notified of significant changes in the recipient's condition. To avoid duplication of services, the Case Management Team should check this agreement before approving admission to determine what the adult day health center is responsible for providing.

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days must not exceed 30 days or 720 hours per plan of care year.

o o o





Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Adult Residential Care

DEFINITION--Adult Residential Care is provided in an Adult Foster Home or a Personal Care Facility. Case Management Teams have a fixed number of slots for this service.

COVERED SERVICES--Adult Residential Care is a bundled service which includes personal care, homemaker services, medication oversight (to the extent permitted under state law), social and recreational activities, and 24-hour on-site response staff to meet scheduled for unpredictable needs and to provide supervision for safety and security.

REQUIREMENTS--Adult Foster Homes and Personal Care Facilities must be licensed by the state. HCBS recipients in these facilities cannot have needs which are beyond the scope of the provider's license.

Adult Foster Homes--According to the rules governing these homes, residents should require only light personal care and cannot have more than 30 consecutive days of skilled nursing visits, not to exceed two hours a day. The latter does not include setting up medications even if this task is performed by a nurse. It may be acceptable for an individual to receive nursing services in excess of the limit if they are not consecutive and if the resident's condition which requires nursing is not chronic. If an individual cannot self-administer medications, they should not be in an Adult Foster Home.

Personal Care Facilities A Bed--An individual in an A bed is limited to 20 consecutive days of nursing services contracted for by the facility at a time. This means that if the resident or the resident's family contracts for the nursing, the latter is not

SECTION:

SERVICES

SUBJECT:

Adult Residential Care

included in the limit, i.e., third party providers not contracting with the facility can provide nursing for longer than 20 consecutive days.

Personal Care Facilities B Bed--A resident of a B bed can receive any skilled services which would be available in a nursing home as long as the facility meets all the conditions outlined in the licensure rule.

LIMITATIONS--Medicaid reimbursement for room and board is prohibited. The provider may not bill Medicaid for services on days the recipient is absent from the facility, unless bed-hold days have been approved by the CMT. (Refer to HCBS 417.) The provider may bill on date of admission and discharge from a hospital or nursing facility. Individuals in adult residential care may not receive the following services under the HCBS program:

1. Personal Assistance;
2. Homemaking;
3. Environmental Modifications;
4. Personal Emergency Response System;
5. Respite; or
6. Meals.

These restrictions apply only when HCBS payment is being made for the Adult Residential service.

REIMBURSEMENT--Reimbursement for Adult Residential Care is calculated using the SLTC-132. (Refer to 899-9 for Adult Residential Care Calculation Instructions.) State supplement for Personal Care Facilities equals \$94.00 per month and for Adult Foster Homes equals \$52.75 per month. Individuals in B-beds are not entitled to state supplement. Reimbursement for Adult Residential Care is limited to a maximum of \$60/day.

Reimbursement for room and board is set by the Department as the current SSI amount minus \$100. The \$100 is kept by the recipient for personal

## SECTION:

SERVICES

## SUBJECT:

Adult Residential Care

needs. This room and board allowance is for a standard room/apartment in the facility. Reimbursement for services covers only those services indicated on page 1 and those indicated on the rate calculation sheet. Items not reimbursable by Medicaid are the responsibility of the recipient and or the recipient's family (i.e., beautician/barber services).

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days may not exceed 30 days or 720 hours per plan of care year.

o o o



Department of Public Health  
and Human Services

SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Behavioral Programming

Reference:

DEFINITION--Behavioral programming provides for continuous in-depth assessment of a recipient with a traumatic brain injury. The service is designed to observe the recipient's behavior and interaction with others in order to develop an appropriate behavior program. Clients are observed in natural environments; i.e., home, day program, etc.

SERVICE REQUIREMENTS--Behavioral programming is provided by an individual with a Bachelor's degree employed by, and working under the direction and supervision of, a licensed neuropsychologist, licensed psychologist, board certified neurologist, board certified psychiatrist, or board certified physiatrist who have experience in working with persons with a traumatic brain injury.

SERVICE LIMITS--The service is provided on a short-term basis.

o o o





Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Case Management

**Reference:** ARM 46.12.1406-1408

DEFINITION--Case management assists recipients in gaining access to needed Home and Community Based Services and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source for the services to which access is gained.

CASE MANAGEMENT ACTIVITIES--Case management includes the following activities:

1. Assessment--A comprehensive evaluation of the person's health, psychosocial, environmental and financial needs. This includes on-going assessment by the team of any evidence of abuse, neglect, or exploitation (Refer to HCBS 309).
2. Care Planning--Development of an appropriate and cost effective plan of care which involves the Case Management Team, the recipient, the attending health care professional, and family members. Refer to HCBS 809 for discussion of Plan of Care requirements.
3. Coordination--Arranging for the provision of necessary services by agencies, family members and volunteers.
4. Monitoring--Monitoring of services being delivered and changes in the person's situation. Monitoring includes prior authorization of payment for all HCBS providers.
5. Initiating--The process of assessment and reassessment of recipient level of care and review plans of care at least every 180 days.

SECTION:

SERVICES

SUBJECT:

Case Management

6. Limitations--A recipient receiving HCBS case management services is not entitled to receive targeted case management services and vis versa.

o o o

Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Chemical Dependency  
Counseling

**Reference:**

DEFINITION--This service provides individual and/or group counseling to recipients who have a substance abuse problem.

SERVICE REQUIREMENTS--Chemical dependency counseling is provided by chemical dependency counselors who have been certified by the state. For individuals with a traumatic brain injury, the counselor must have completed a training program specific to individuals with traumatic brain injury. The counselor must show proof in the form of a training certificate or diploma indicating that they have successfully completed such a program.

o o o





Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Cognitive Rehabilitation

**Reference:**

DEFINITION--Cognitive rehabilitation is a service for persons with a traumatic brain injury. It is designed to teach individuals to function with their injury by reinforcing, strengthening or reestablishing previously learned patterns of behavior, or by establishing new patterns of behavior or other compensatory mechanisms.

SERVICE REQUIREMENTS--Cognitive rehabilitation is provided by an agency under the direction of a licensed psychologist, licensed neuropsychologist, board certified neurologist, board certified psychiatrist or board certified physiatrist who have experience in working with persons with a traumatic brain injury.

SERVICE LIMITATIONS--Cognitive rehabilitation is limited to 15 hours per plan of care year. Services in excess of 15 hours must be prior authorized by the Department.

This service can be provided in an individual's home, work environment, or other community setting.

o o o



Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Community Residential  
Rehabilitation

**Reference:**

DEFINITION--Community residential rehabilitation is comprehensive day treatment plus a residential component.

SERVICE REQUIREMENTS--Community residential rehabilitation is provided by an agency under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuropsychologist, a licensed psychologist, therapists and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program for Persons with a Traumatic Brain Injury or receive such accreditation within two years of commencement of this service under the HCBS program.

SERVICE LIMITATIONS--This service is limited to Care Category 3 (CC3) recipients who have a traumatic brain injury.

REFERRAL PROCESS--The referral process for community residential rehabilitation is identical to the referral process for comprehensive day treatment. (Refer to HCBS 510.)

o o o



Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Comprehensive Day Treatment

**Reference:**

**DEFINITION**--Comprehensive day treatment is a non-residential program for persons with a traumatic brain injury. It is intended to maximize functional independence through therapeutic intervention which provides intensive therapies three to five days a week. Recipients are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and relearn day to day living skills. The goal of this program is to facilitate integration into the community in addition to reducing the level of disability of the recipient.

**SERVICE REQUIREMENT**--Comprehensive day treatment is provided by an agency under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuropsychologist, a licensed psychologist, therapists and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program of Persons with a Traumatic Brain Injury or receive such accreditation within two years of commencement of this service under the HCBS program.

**SERVICE LIMITATIONS**--This service is limited to Care Category 3 (CC3) recipients who have a traumatic brain injury.

**REFERRAL PROCESS**--

**New Referrals**--The following steps are followed for new referrals to the TBI Program; i.e. recipients who are not yet HCBS recipients:



## SECTION:

## SERVICES

## SUBJECT:

## Comprehensive Day Treatment

1. Recipient meets Level of Care;
2. Make referral to on-site Case Management Team (CMT) in Billings or Missoula;
3. On-site CMT will notify recipient that they have received the referral and will be placed on a waiting list;
4. On-site CMT conducts a paper review of recipient;
5. If recipient appears to be appropriate for the TBI program, a referral is made to Bridges or Headway;
6. TBI program staff meets with recipient and CMT if necessary;
7. If the recipient, TBI program staff, and CMT all agree the program is appropriate, recipient enrolls in HCBS CC3 heavy care slot. Recipient obtains financial eligibility and a plan of care is developed;
8. Send Prior Authorization to state office via the RPO;
9. Recipient is admitted to TBI program for a two-week evaluation;
10. After a two-week period, conduct a team meeting and begin discharge planning;
11. CMT will have formal monthly meetings with TBI program staff, recipient, and others. Informal meetings will be scheduled as necessary;
12. Recipient is discharged to local CMT;
13. Request a full level of care screen from Mountain-Pacific Quality Health Foundation.

## SECTION:

SERVICES

## SUBJECT:

Comprehensive Day Treatment

Current HCBS Recipients from Other Service Areas

1. Refer to on-site CMT. Let on-site CMT know whether local CMT is willing to participate in monthly team meetings to monitor recipient status;
2. On-site CMT conducts paper review of recipient;
3. If recipient appears to be appropriate for the TBI program, a referral is made to TBI program staff;
4. TBI program staff meets with recipient;
5. If recipient is appropriate for TBI program, place on a waiting list for Bridges or Headway and refer for a full level of care screen by local CMT;
6. Set an admission date for Bridges or Headway;
7. Discharge from local CMT (discharge date should be day before admit to TBI program date). Local CMT can fill empty slot;
8. On-site CMT enrolls recipient in a CC3 heavy care slot, prepares plan of care and sends appropriate requests to state office via the RPO;
9. On-site CMT will contact local CMT for participation in team meetings as agreed upon;
10. A full level of care screen will be requested by on-site CMT when recipient is ready for discharge from TBI program;
11. On-site CMT discharges recipient via discharge sheet;
12. If recipient returns to local community, CMT must have a slot available.

## SECTION:

SERVICES

## SUBJECT:

Comprehensive Day Treatment

13. Local CMT enrolls recipient in CC2 slot and sends intake sheet to state office;

**Current Missoula or Billings HCBS Recipients**

1. Determine appropriateness of service;
2. Discharge from regular slot. Send Discharge Sheet to state office;
3. Request a full level of care screen;
4. Place in CC3 heavy care slot and send appropriate paperwork to Regional Program Officer for approval.

**Upon Discharge from TBI Program**

1. At discharge from TBI program, CMT must have a slot available for the recipient.
2. Send Discharge Sheet from CC3 to state office;
3. Send Intake Sheet for CC2 to state office;
4. Amendment to care plan and cost sheet to reflect change in status;
5. If recipient is going into supported living slot, send in amendment to prior authorization.

o o o

Department of Public Health  
and Human Services

SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Day Habilitation

Reference:

DEFINITION--Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care.

Day habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

SERVICE REQUIREMENTS--Providers of day habilitation must be licensed Adult Day providers.

o o o







Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Dietitian

**Reference:** ARM 46.12.1480-1482

DEFINITION--Dietitian Services mean services related to the management of a recipient's nutritional needs.

COVERED SERVICES--Dietitian Services include the following:

1. evaluation and monitoring of nutritional status;
2. nutrition counseling;
3. therapy; and
4. education and research.

SERVICE REQUIREMENTS--Dietitian services must be provided by a registered dietitian or a licensed nutritionist. Registered dietitians must meet the qualifications in 37-21-302 MCA and licensed nutritionists must meet the licensing requirements in 37-25-302, MCA.

o o o



Department of Public Health  
and Human Services

## SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Environmental Accessibility  
Adaptations

DEFINITION--Environmental accessibility adaptations are those physical adaptations to the recipient's home designed to maintain or improve an individual's ability to remain at home. Environmental adaptations may include modifications to a personal vehicle if it will allow the individual to be more independent. The procedure code for this service also includes reimbursement for consultation.

Consultation must be provided only by enrolled providers. These providers are construction management for environmental accessibility adaptations and for van modifications. (Refer to HCBS 513B.)

GENERAL SERVICE REQUIREMENT--When providing this service, the case management team must always take into account the nature of the recipient's disease or disability. If there is a reasonable expectation that the recipient's condition will deteriorate, this factor must be taken into account when making the modification. Environmental accessibility adaptations:

1. Must be functionally necessary and relate specifically to the individual's disability;
2. Must provide for the individual's accessibility, increased independence, or safety in the home;
3. Must be based on a reasonable expectation that the environmental adaptation will promote the individual's functional abilities or the ability of a caregiver or service provider to maintain the individual in the home;

## SECTION:

SERVICES

## SUBJECT:

Environmental Accessibility  
Adaptations

4. Must be the most adequate and cost effective modification which can meet the needs of the recipient;
5. May include the installation of specialized electrical and plumbing systems to accommodate the medical equipment and supplies which are necessary for the welfare of the individual;
6. Will be limited to one time purchase. The department at its discretion may authorize an exception to this limit. Any such exception must be prior authorized by the Department;
7. Do not constitute general housing or appliance maintenance, including but not limited to plumbing, heating systems, and leisure items;
8. Must meet Americans with Disabilities Act (ADA) and American National Standard Institute (ANSI) standards and specifications; and
9. Jobs in excess of \$8000 must be prior authorized by the Regional Program Officer.

Case management teams must use a consultant for all environmental modifications.

o o o

Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Consultant

DEFINITION--Consultants for environmental modifications oversee projects from beginning to end. This includes initial inspection, determination of process, finding contractors, receiving and evaluating bids, choosing a contractor, approving a job, final inspection, and payment to the contractor. The consultant will submit claims for the entire job.

CONSULTANT REQUIREMENTS--Consultants for environmental accessibility adaptations must be prior approved by the Department and enrolled by Consuletec as a Medicaid provider. The qualifications for a consultant are as follows:

1. Must have a minimum of five years experience in project management and/or construction management. Must provide references for jobs in which they have been a project manager or construction manager. Must specifically have experience in cost estimates, scheduling, sub-contracting procedures and bidding.
2. Must have a project coordinator dedicated to the HCBS Program.
3. Must show have a quality assurance component for HCBS jobs.
4. Must maintain current Certificate of Contractor Registration through the State of Montana, Department of Labor and Industry
5. Must maintain current local city license.
6. Must have experience in managing the construction of accessible housing.



SECTION:	SUBJECT:
SERVICES	Consultant

In addition, the consulting agency must make the following assurances to the Department:

1. The consultant will document and track time spent on a job by client;
2. The consultant will develop design documents and specifications for construction bids;
3. The consultant will review and evaluate all bids, and make recommendations for contract awards;
4. The consultant will receive, review and disseminate all submittals;
5. The consultant will establish a register of items for control purposes;
6. The consultant will conduct observation reviews at the site for management control;
7. The consultant will monitor and control all construction record documents;
8. The consultant will prepare and disseminate "change" documents for signature by case management teams;
9. The consultant will log records to be maintained to show status of issues and claims at any given time in each individual project;
10. The consultant will conduct reviews as necessary, record progress, direction and any disputes for recording purposes;
11. The consultant will ensure compliance with contract at all times;
12. The consultant will show professionalism in working with individuals who are disabled or elderly at all times;

## SECTION:

SERVICES

## SUBJECT:

Consultant

13. The consultant will maintain contact with the appropriate case management team at all times; and
14. The consultant will assume a standard AIA contract with \$1,000,000 commercial general liability insurance with a \$2,000,000 products-completed operations aggregate limit.

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

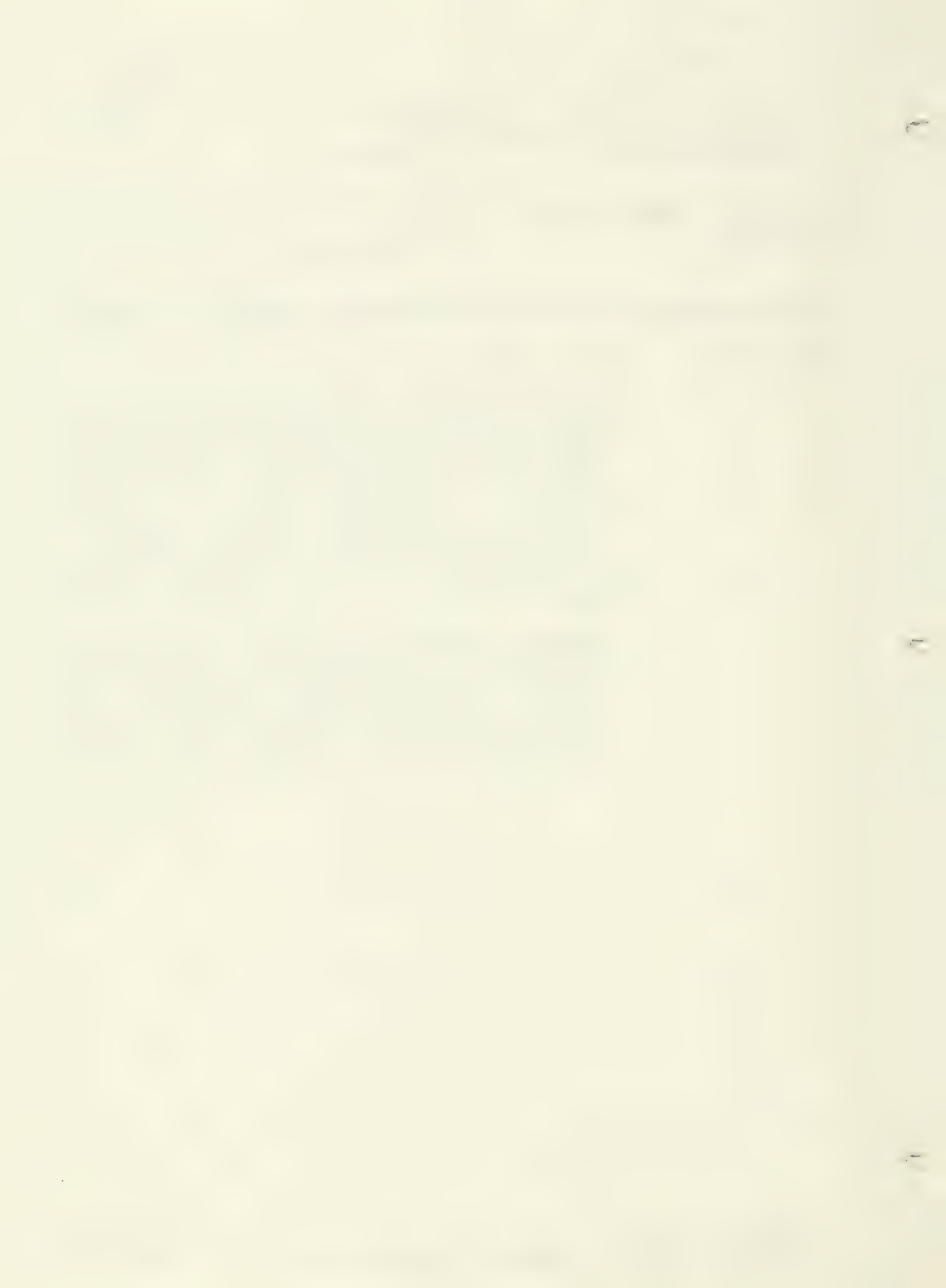
SUBJECT:  
Habilitation

References: ARM 46.12.1435-1437

DEFINITION--Habilitation services are those services designed to assist individuals to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in home and community settings. Habilitation services provide social, training and/or health-related services to ensure optimal functioning. Habilitation services do not include educational services which are not reimbursable under HCBS.

INCLUDED SERVICES--Habilitation also includes independent living evaluations and training services which will enhance the recipient's ability to achieve maximum independence in homemaking, personal hygiene, money management, transportation, housing and use of community resources.

o o o





Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Homemaker

Reference: ARM 46.12.1425-1427

DEFINITION--Homemaker services consist of general household activities performed by an individual or agency. Homemaker services are provided to recipients unable to manage their own home or when the individual normally responsible for homemaking is absent. Homemaker services do not include personal care services available under State Plan Medicaid.

COVERED SERVICES--Homemaker activities include but are not limited to the following:

- Household management necessary for maintaining and operating a home. This may include assisting the recipient to find and relocate to other housing; general housecleaning and meal preparation; performance of household chores such as heavy cleaning (e.g., washing windows or walls); yard care; walkway maintenance; minor home repairs; wood chopping and stacking.
- Teaching services to improve a recipient or family's skills in household management and social functioning.
- Social restorative services consisting of assistance which will further a recipient's involvement with activities and other persons. This may include reimbursement to the homemaker for escort to social functions if the recipient's needs require such a service.
- Chore services for households requiring extensive cleaning beyond the scope of general household housecleaning. When

## SECTION:

SERVICES

## SUBJECT:

Homemaker

billing for this service, use the appropriate designated procedure code for chore service.

SERVICE REQUIREMENTS--Homemaker services must meet the following criteria:

1. Services shall be provided only after other homemaker services provided by the Department or through other state or federally funded programs have been exhausted.
2. Homemakers must be physically and mentally able to perform the duties required and able to follow written orders.
3. Homemaker Services will be provided only to recipients who reside in their own home.

o o o

Department of Public Health and Human Services	SECTION:  SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Nutrition

**Reference:** ARM 46.12.1456-1458

DEFINITION--Nutrition services include the provision of congregate and home-delivered meals.

SERVICE REQUIREMENTS--Congregate or home delivered meals must be provided as defined in ARM 46.4.302 through 46.4.306.

AREA AGENCY ON AGING (AAA)--Meals may be purchased from an AAA if:

- The AAA provides the service.
- The AAA has a fixed rate for the service which it charges the general public. The Home and Community Based Services reimbursement rate cannot exceed the rate charged to the general public.
- If the AAA does not have a fixed rate, meals can only be purchased if it is a meal that the AAA normally does not provide or the AAA has no more funds available for meals.

REIMBURSEMENT LIMITS--No more than two meals a day shall be provided to recipients through congregate or home-delivered meals. Providing more than two meals a day constitutes a full nutritional regimen or "board", which is not reimbursable under the Home and Community Based Services Program.

o o o



Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Extended State Plan Service:  
Occupational Therapy

**References:**

ARM 46.12.1441-1443

DEFINITION--Outpatient occupational therapy services provided for maintenance or habilitative purposes.

MAINTENANCE OCCUPATIONAL THERAPY--Maintenance occupational therapy is provided when there is no expectation that the recipient's condition will improve significantly in a reasonable and predictable period of time. Maintenance occupational therapy is only reimbursed under the Home and Community Based Services Program.

ELIGIBLE PROVIDERS--An Occupational Therapist must be:

1. Registered by the American Occupational Therapy Association; or
2. A graduate from a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

SERVICE LIMITATION:

1. There is no visit limitation for maintenance occupational therapy.
2. Occupational therapy services must be provided outside a hospital setting.

o o o





Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Personal Assistance

DEFINITION--Personal assistance services under the Home and Community Based Services Program (HCBS) may include supervision for health and safety reasons, socialization, escort and transportation for nonmedical reasons, specially trained attendants for recipients with extensive needs, or an extension of State Plan personal assistance services.

GENERAL PROVISIONS AND SERVICES--A personal assistant is an employee of a provider agency. Personal assistance services must meet the following criteria:

1. Personal assistance services must be provided by a provider under contract with the Department to provide State Plan personal assistance.
2. Individuals enrolled in the self-directed program may also self-direct their HCBS personal assistance services.
3. **HCBS personal assistance** may be a combination of self-directed and agency directed services.

REFERRAL PROCEDURES--All referrals for personal assistance services to HCBS recipients must be forwarded to the provider agency on a Personal Assistance Services Referral/Amendment Form (DPHHS-MA-138). (Refer to Appendix 899-14.)

PERSONAL ASSISTANCE SERVICES MANUAL--The Department has developed a manual for provider agencies that outlines all policies and procedures relating to the Personal Assistance Services Program. This manual should be referred to for policy information.

## SECTION:

SERVICES

## SUBJECT:

Personal Assistance

EFFECT ON PLAN OF CARE COSTS--Only those personal assistance services provided under HCBS are included on the HCBS plan of care cost sheet. The provision of State Plan personal assistance services as defined in ARM 46.12.555 should be reflected on the "Other Treatment/Therapies/Social Services" section on the HCBS plan of care.

SERVICE LIMITATIONS--Personal assistants providing HCBS personal assistance only may be members of the recipient's family except that payment will not be made for services furnished to a minor by the recipient's parent, step-parent, or adoptive parent, or to a recipient by that recipient's spouse.

NURSE SUPERVISION FOR PERSONAL ASSISTANTS--This service is for recipients who are not receiving state plan personal assistance services and require a nurse for the supervision of the HCBS specific personal assistance. This service is billable under procedure code Z0574. Billable time for nurse supervision is:

1. Intake time. This includes the time to complete the plan for services and orient the recipient to the program in the recipient's home, as long as you start services for this individual.
2. Time spent in providing specific recipient orientation or training to an attendant. This DOES NOT include going over the schedule.
3. Time spent charting specific to one recipient. This would include such activities as incident reporting and service plan development.
4. Time spent in case conferences with other providers and/or family members and/or recipients.

## SECTION:

SERVICES

## SUBJECT:

Personal Assistance

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days may not exceed 30 days or 720 hours per plan of care year.

o o o





Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Personal Emergency Response  
System

**Reference:**

ARM 46.12.1450-1452

DEFINITION--The personal emergency response system (PERS) is an electronic, telephonic or mechanical system used to summon assistance in an emergency situation. The system alerts medical professionals, support staff or other designated individuals to respond to a recipient's emergency request. PERS also includes systems such as Wandergard used for the supervision and safety of individuals with cognitive disabilities.

SERVICE REQUIREMENT--PERS must be connected to a local emergency response system with the capacity to activate emergency medical personnel.

SERVICE LIMITATIONS--Reimbursement is not available for the purchase, installation or routine monthly charges of a telephone under this service. The systems used to summon assistance have an upper rate of \$35.00. The systems used for supervision and safety have an upper rate of \$69.00.

o o o



Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Extended State Plan Service:  
Physical Therapy

**References:**

ARM 46.12.1444-1446

DEFINITION--Outpatient physical therapy services provided for habilitation or maintenance purposes.

MAINTENANCE PHYSICAL THERAPY--Maintenance physical therapy is provided when there is no expectation that the recipient's condition will improve significantly in a reasonable and predictable period of time. Maintenance physical therapy is reimbursable only under the Home and Community Based Services Program.

ELIGIBLE PROVIDERS--Physical therapy services must be provided by a licensed physical therapist. A physical therapist's assistant, student or aide may assist in the practice of physical therapy under direct supervision of the licensed physical therapist who is responsible for and participates in the treatment program.

SERVICE LIMITATIONS:

1. There is no visit limitation for maintenance physical therapy.
2. Physical therapy services must be provided outside a hospital setting.

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Prevocational Training

Reference:

DEFINITION--Prevocational training services:

1. are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Education of the Handicapped Act;
2. are aimed at preparing an individual for paid or unpaid employment, but are not job task oriented;
3. include teaching such concepts as compliance, attending, task completion, problem solving and safety; and
4. are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

When compensated, recipients are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the recipient's plan of care as directed to habilitative, rather than explicit employment objectives.

SERVICE REQUIREMENTS--Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

o o o





Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Private Duty Nursing

DEFINITION--Private duty nursing services are medically necessary services provided to recipients who require continuous in-home nursing care that is not available from a home health agency. These services are provided to an individual at home.

SERVICE REQUIREMENTS--Nursing services must be provided by a registered or licensed practical nurse licensed to practice in the State of Montana. Nursing services provided by an LPN must be supervised by an RN, physician, dentist, osteopath or podiatrist authorized by state law to prescribe medication and treatment. Nursing services must meet the following criteria:

1. Be provided by a registered nurse or licensed practical nurse. Persons providing nursing services must meet the licensure and certification requirements provided in ARM 8.32.401 et. seq.
2. Nursing Services can be provided only when Home Health Agency Services as provided in ARM 46.12.550 are not appropriate or available.
3. The plan of care must document the recipient's specific health-related need for nursing. Use of a nurse to routinely check skin condition, review medication use or perform other nursing duties in the absence of a specific identified problem, is not allowable. General statements such as "monitor health needs" are not considered sufficient documentation for the service.

## SECTION:

SERVICES

## SUBJECT:

Private Duty Nursing

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days may not exceed 30 days or 720 hours per plan of care year.

o o o

Department of Public Health  
and Human Services

SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Psychosocial Consultation

References: ARM 46.12.1462-1464

DEFINITION--Psychosocial consultation services are those services provided by a licensed mental health professional which are within the scope of the practices of the profession. Mental health services are limited to those allowed under 37-17-102(5), MCA.

A licensed mental health professional is a licensed clinical psychologist, licensed clinical social worker, or licensed professional counselor.

COVERED SERVICES--Services include consultation with providers and caregivers directly involved with the recipient and the development and monitoring of behavior programs. Psychological services that involve direct counseling and treatment of the recipient are included under the State Plan Medicaid Program and are not reimbursable as an HCBS service.

Psychosocial consultation services are in addition to the limits of the State Plan program.

SERVICE USAGE--This service should be used to assist direct caregivers in dealing with difficult situations or provide general consultation for the appropriate delivery of HCBS.

o o o





Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Registered Nurse  
Supervision

**Reference:** ARM 46.12.1468-1470

DEFINITION-RN Supervision is supervision by a registered nurse of a LPN who is providing private duty nursing services under the Home and Community Based Services program.

SERVICE REQUIREMENTS--RN Supervision services must meet the following criteria:

1. Be provided by a registered nurse. Persons providing RN Supervision services must meet the licensure and certification requirements provided in ARM 8.32.401 et. seq.
2. The registered nurse can be from a home health agency, independent agency, or can be the Case Management Team nurse.
3. The Case Management Team will have input in the amount and degree of supervision required and the projected cost.
4. RN Supervision is billable under procedure code Z0528.

o o o



Department of Public Health  
and Human Services

## SECTION:

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Respiratory Therapy

Reference: ARM 46.12.1474-1476

DEFINITION--Respiratory therapy includes direct treatment, ongoing assessment, equipment monitoring and upkeep, pulmonary education and rehabilitation.

SERVICE REQUIREMENTS--Respiratory Therapy must meet the following criteria:

1. Be furnished in the recipient's home;
2. Be provided by a registered respiratory therapist as defined by the National Board for Respiratory Care; and
3. A certified respiratory therapy technician may assist under the direct supervision of a registered respiratory therapist or physician responsible for and participating in the recipient's treatment program.

SERVICE LIMITATION--Respiratory Therapy Services are limited to 24 hours per recipient per plan of care year. Services in excess of this limit must be prior authorized by the Department. (Refer to HCBS 410 for Prior Authorization procedures.)

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Respite Care

Reference: ARM 46.12.1438-1440

DEFINITION--Respite Care is temporary, short-term care provided to recipients in need of supportive care to relieve those persons who normally provide the care.

SERVICE REQUIREMENTS--Respite Care must meet the following criteria:

1. Be provided only on a short-term or temporary basis such as part of a day, weekends or vacation periods.
2. Be provided in the recipient's residence or by placing the recipient in another private residence, licensed foster home or other community setting, hospital, personal care facility, residential hospice, group home, therapeutic camp for children or adults with disabilities, licensed nursing facility or licensed intermediate care facility for the mentally retarded (ICF/MR). Payment for Respite Care provided in a hospital must be prior authorized by the Department.
3. Respite Care providers must be determined by the Case Management Team to be:
  - a. Physically and mentally qualified to provide Respite Care; and
  - b. Aware of emergency assistance systems.
4. Persons who provide Respite Care may also be required by the Case Management Team to have knowledge of the recipient's physical and mental conditions, medications, and be capable of administering basic first aid.



## SECTION:

SERVICES

## SUBJECT:

Respite Care

5. When respite care is provided, the provision of, or payment for other duplicative services under HCBS is precluded (e.g., payment for respite when recipient is in Adult Day Care).

REIMBURSEMENT LIMIT--When Respite Care is provided by a nursing facility, reimbursement may not exceed the specific facility's Medicaid per diem rate unless otherwise negotiated by the Department for CC3 recipients. (Refer to HCBS 599-6 for the Medicaid per diem rate.)

o o o

Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Special Child Care for  
Children with AIDS

**Reference:**

DEFINITION--This service provides care for children with AIDS who, because of their disability, cannot be served in traditional child care settings.

SERVICE REQUIREMENT--A provider of this service must be physically and mentally able to perform the duties required, and must be literate and able to follow written orders.

SERVICE LIMITS--This service is limited to children with AIDS or children who are HIV positive.

o o o



Department of Public Health and Human Services	SECTION:  SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Specialized Medical Equipment and Supplies

## Reference:

DEFINITION--Specialized medical equipment and supplies are those items designed to maintain or improve the individual's ability to remain at home and function in the community. The procedure code for this service also includes reimbursement for consultation.

REQUIREMENTS--

1. Specialized medical equipment and supplies:
  - a. Must be functionally necessary and relate specifically to the individual's disability;
  - b. Must provide for the individual's accessibility, increased independence, health, or safety;
  - c. Must be based on a reasonable expectation that the item will promote the individual's functional abilities or the ability of a caregiver or service provider to maintain the recipient in the home;
  - d. Must be the most cost effective item which can meet the needs of the recipient;
  - e. Will be limited to a one time purchase. The department at its discretion may authorize an exception to this. Any exception must be prior authorized by the department;
  - f. Include the purchase of environmental control units for the recipient upon evaluation by a technical consultant to determine which type of unit best meets the recipient's needs;

SECTION:

SERVICES

SUBJECT:

Specialized Medical Equipment  
and Supplies

g. For service animals may include:

- i. ancillary supplies if specifically related to the performance of the service animal to meet the specific needs of the individual. If not provided by the training organization, these supplies may include leashes, harness, backpack, and mobility cart; and
- ii. Ancillary care for the service animal if specifically related to the health and maintenance of that animal. These services may include veterinarian care, transportation for veterinarian care, license and/or registration. Grooming may also be included but only if the individual or primary care giver is unable to provide for this maintenance.

h. May include CMT authorization for the purchase of an already modified/adapted van when the following criteria are met:

- i. The adapted van is to be purchased exclusively to provide transportation for the consumer;
- ii. Purchase of the adapted van will increase consumer independence and self-sufficiency;
- iii. The CMT will determine that there are no other alternatives to meet the consumer transportation needs;
- iv. All other sources of funding including but not limited to consumer financing, consumer contribution (trade in of current van or other vehicle), family resources, PASS plans, and Vocational Rehabilitation must be explored and exhausted;
- v. Prior to purchase, the adapted van must be inspected by a reputable (ASE) certified mechanic and determined to be in good condition;



## SECTION:

SERVICES

## SUBJECT:

Specialized Medical Equipment  
and Supplies

- vi. The consumer will be responsible for license and insurance. Full coverage will be required;
  - vii. All drivers of the van must have a current valid drivers license;
  - viii. Prior to purchase of the van, the consumer/guardian will be offered a consumer agreement to sign which states when the consumer no longer requires the use of the van it will be released for use by another consumer;
  - ix. Whenever possible the purchase of the van should include a warranty/extended warranty; and
  - x. The consumer is responsible for all repairs, maintenance and upkeep of the van.
2. Specialized medical equipment and supplies shall not constitute:
- a. Those items used for leisure and recreational purposes only and not determined to be necessary for the recipient to remain in the home;
  - b. Items of clothing;
  - c. Basic household furniture;
  - d. Items which are educational in nature such as computers, software, or books unless these are required for an environmental control unit;
  - e. For service animals:
    - i. Pets, companion animals, social therapy animals;
    - ii. Guard, police, rescue, sled, tracking, or any other animal not specifically designated as a service animal;

SECTION:

SERVICES

SUBJECT:

Specialized Medical Equipment  
and Supplies

iii. Wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

3. Certain items for short-term use may be leased or rented instead of purchased.

CONSULTATION: A consult is mandated for the following items by the appropriate professional:

1. Environmental control units by MonTech;
2. Dietary supplements by an MD, dietitian or nutritionist;
3. Augmentative communication devices by a speech therapist or language pathologist;
4. Air conditioner/purifier - letter of medical necessity from an MD;
5. Wheelchairs, scooters, four-wheel walkers, standing frames and stair climbers by an occupational or physical therapist or an assistive technology practitioner;
6. Computer interface systems by MonTech;
7. Switches and special phones by MonTech;
8. Service dogs by an occupational therapist; and
9. Any other new or unusual high tech item by MonTech.

SERVICE  
ANIMALS:

DEFINITION--Service animal means any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items. A service animal is an adaptive intervention specially trained to do work or perform tasks which benefit an individual with a disability or an individual who is aged. This

## SECTION:

SERVICES

## SUBJECT:

Specialized Medical Equipment  
and Supplies

service animal is intended to increase autonomy, to decrease functional limitations, to access the home or public environment, to provide for safety, and to reduce the risk of institutionalization.

PROVIDER REQUIREMENTS--To be a qualified provider of service animals a provider must:

1. Have successfully placed three service animals within the past eight years;
2. Have submitted a Request for Information and Qualifications proposal to DPHHS for approval; and
3. Have submitted to DPHHS the Service Animals-Provider Assurances form, DPHHS-MA-142 (See HCBS 899-23).

PROCUREMENT PROCEDURE--All requests must be submitted to and approved by the Service Animal Selection Committee composed of the designated Service Animal Committee Coordinator, local Regional Program Officer, Case Management Team, and the applicant prior to the commencement of any training. Procedures for the procurement of service animals will be as follows:

1. Case Management Teams must follow the steps outlined in the Service Animals-Case Management Team's Role handout (See HCBS 599-3).
2. Recipients must follow the steps outlined in the Service Animals-Consumer's Role handout (See HCBS 599-4) and sign and comply with the requirements in the Service Animals-Stewardship form, DPHHS-MA-147 (See HCBS 899-24).

REIMBURSEMENT--Reimbursement for service animals is a two-part process. Initial reimbursement at 50% of the contracted amount agreed upon by the Case Management Team and the selected training program will be authorized at the time the Service Animal Selection Committee is notified by the evaluator of the successful completion of the evaluation by the working team. The second installment at 50% of the contracted amount will be authorized at the time the Service Animal Selection Committee is notified

## SECTION:

SERVICES

## SUBJECT:

Specialized Medical Equipment  
and Supplies

by the evaluator of the successful completion of the Follow-up Evaluation to determine whether the efficacy of the working team meets department standards.

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Specially Trained Attendant

DEFINITION--This service provides personal assistance by attendants who have been specially trained to meet the unique needs of the HCBS recipient.

REQUIREMENTS--Personal assistants who assist individuals with a traumatic brain injury must receive an additional 10 hours of TBI-specific training and four hours of recipient-specific training. Assistants who assist individuals with physical disabilities must receive an additional 10 hours of recipient-specific training and four hours of disability-specific training. It is the responsibility of the provider agency to ensure that assistants are appropriately trained.

QUALIFICATION FOR SERVICE--Recipients must meet the following qualifications to be eligible for a specially trained attendant:

1. Person with a TBI whose needs cannot be met by standard personal assistance services (PAS);
2. Person with a severe physical disability whose needs cannot be met by standard PAS;
3. Person with dementia whose needs cannot be met by standard PAS; and
4. Person who has exhausted standard PAS providers as a result of problem behavior.

Use of specially trained attendant must be prior authorized by a Regional Program Officer via the prior authorization form (DPHHS-MA-149). Refer to HCBS 899-22.



## SECTION:

SERVICES

## SUBJECT:

Specially Trained Attendant

SERVICE LIMITATIONS--Specially trained attendants may be members of the recipient's family except that payment will not be made for services furnished to a minor by the recipient's parent, step-parent, or adoptive parent, or to a recipient by that recipient's spouse.

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days may not exceed 30 days or 720 hours per plan of care year.

o o o

Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Extended State Plan Service:  
Speech Therapy and Audiology

References: ARM 46.12.1447-1449

DEFINITION--Speech therapy and audiology services for maintenance and habilitative purposes.

MAINTENANCE SPEECH THERAPY AND AUDIOLOGY SERVICES--Maintenance speech therapy is provided when there is no expectation that the recipient's condition will improve significantly in a reasonable and predictable period of time. Maintenance speech therapy is reimbursable only under the Home and Community Based Services Program. Audiology services include screening and evaluation of recipients with respect to hearing functions.

SERVICE LIMITATIONS--Speech therapy services must be provided outside a hospital setting.

o o o



Department of Public Health  
and Human Services

**SECTION:**

SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Supported Employment

**Reference:**

DEFINITION--Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by HCBS recipients, including supervision and training.

COVERED SERVICES--When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by HCBS recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

SERVICE REQUIREMENTS--Supported employment services rendered under HCBS are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

## SECTION:

SERVICES

## SUBJECT:

Supported Employment

1. Incentive payments made to an employer of beneficiaries to encourage or subsidize employer's participation in a supported employment program;
2. Payments that are passed through to beneficiaries of supported employment programs; or
3. Payments for vocational training that is not directly related to a beneficiary's supported employment program.

Transportation will be provided between the recipient's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the recipient receives habilitation services in more than one place) as a component part of habilitation services.

The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Supported Living

DEFINITION--Supported living is a comprehensive habilitation service designed to support individuals with traumatic brain injuries, or other severe disabilities, in the community. This service is to transition individuals from an institutional setting to a more independent living situation.

COVERED SERVICES--Supported living is a bundled service which includes: independent living evaluation, homemaking, habilitation aides, behavioral programming, non-medical transportation, specially trained attendants, day habilitation, residential habilitation, prevocational training, supported employment, 24-hour availability of staff for supervision and safety, and service coordination to coordinate supported living services.

SERVICE REQUIREMENTS--A provider of this service must be CARF accredited in integrated living, congregate living, personal social and community services, community employment services, and work services; or have ACD accreditation. Providers must also have two years experience in providing services to persons with physical disabilities.

SERVICE LIMITS--As this is a high-cost service, enrollment is limited. Supported living candidates must be prior approved by the Department by following the process for CC3 referrals outlined in section HCBS 404 of this manual.

## SECTION:

SERVICES

## SUBJECT:

Supported Living

BED-HOLD DAYS--Providers of this service may be eligible for "bed-hold" payment if authorized by the Case Management Team. "Bed-hold" days are days on which the recipient is either in the hospital, nursing facility, or on vacation. Payment for "bed-hold" days may not exceed 30 days or 720 hours per plan of care year.

o o o

Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Transportation

Reference: ARM 46.12.1453-1455

DEFINITION--Transportation means travel furnished by common carrier or private vehicle for non-medical reasons as defined in the individual plan of care. Medical transportation is available under the State Plan Medicaid Program.

SERVICE REQUIREMENTS--Transportation Services must meet the following criteria:

1. Be provided only after volunteer or other publicly funded transportation programs have been exhausted;
2. Be provided by the most cost effective mode; and
3. Be provided only when necessary to transport recipients to and from activities that are included in the HCBS plan of care or to run essential errands for clients who are not receiving State Plan personal assistance services.
4. Transportation providers must provide proof of:
  - a. A valid Montana driver's license; and
  - b. Adequate automobile insurance.

o o o



Department of Public Health  
and Human Services

SECTION:  
SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Consumer/Family Intensive  
Support Service

DEFINITION--Consumer Intensive Support Service provides a unique set of supports to a recipient and family not yet eligible for hospice services. These include: pain & symptom management; guidance and support; volunteer coordination; and limited financial resources for the aforementioned.

REQUIREMENTS--

Pain & Symptom Management Coordination-- Provided by an RN with knowledge of current practices of pain management. This hands on provider must be approved by a Pain & Symptom Management Consultant. The upper limit is \$45.00 per hour.

Guidance & Support--Provided by an individual selected by the CMT and recipient to provide psychosocial guidance and support to the recipient, family, or significant others for issues relating to loss, grief, and adjustment to chronic disease, disability, or aging. The upper limit is \$35.00 per hour.

Volunteer Coordinator--Provided by an individual selected by the CMT to coordinate volunteer services approved by the CMT or the Pain & Symptom Management Coordinator as prescribed by a health-care professional, in support of one of the above services. The upper limit is \$35.00 per hour.

Specialized equipment or supplies required to supplement this service, that is not covered under state plan Durable Medical Equipment, must be billed under HCBS Specialized Equipment procedure code.

o o o





SENIOR AND LONG TERM CARE SERVICES

Subchapter 14

Home and Community-based Services

Rules 37.40.1401      Home and Community-based Services for  
Elderly and Physically Disabled Persons  
Authority and Scope of Program

Rules 02 through 05 reserved

37.40.1406      Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Services

37.40.1407      Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
General Requirements

37.40.1408      Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Enrollment

Rules 09 through 14 reserved

37.40.1415      Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Reimbursement

Rules 16 through 19 reserved

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

- Rule 37.40.1420 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Plans of Care
- 37.40.1421 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Cost of Plan of Care
- Rules 22 through 25 reserved
- 37.40.1426 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Notice and Fair Hearing
- Rules 27 through 29 reserved
- 37.40.1430 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Case Management, Requirements
- Rules 31 through 34 reserved
- 37.40.1435 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Adult Residential Care, Requirements
- Rule 36 reserved
- 37.40.1437 Home and Community-based Services  
Treatment for Elderly and Physically  
Disabled Persons: Community Residential  
Rehabilitation, Requirements
- 37.40.1438 Home and Community-based Services for  
Elderly and Physically Disabled Persons:  
Supported Living, Requirements
- Rules 39 through 44 reserved

SENIOR AND LONG TERM CARE SERVICES

- Rule 37.40.1445 Home and Community-based Services for Elderly and Physically Disabled Persons: Adult Day Health
- 37.40.1446 Home and Community-based Services for Elderly and Physically Disabled Persons: Comprehensive Day Treatment, Requirements
- 37.40.1447 Home and Community-based Services for Elderly and Physically Disabled Persons: Personal Assistance, Requirements
- 37.40.1448 Home and Community-based Services for Elderly and Physically Disabled Persons: Habilitation, Requirements
- 37.40.1449 Home and Community-based Services for Elderly and Physically Disabled Persons: Specially Trained Attendant Care, Requirements
- 37.40.1450 Home and Community-based Services for Elderly and Physically Disabled Persons: Homemaking, Requirements
- 37.40.1451 Home and Community-based Services for Elderly and Physically Disabled Persons: Respite Care, Requirements
- 37.40.1452 Home and Community-based Services for Elderly and Physically Disabled Persons: Specialized Child Care for Children with AIDS, Requirements

Rules 53 through 59 reserved

SENIOR AND LONG TERM CARE SERVICES

- Rule 37.40.1460 Home and Community-based Services for Elderly and Physically Disabled Persons: Outpatient Occupational Therapy, Requirements
- 37.40.1461 Home and Community-based Services for Elderly and Physically Disabled Persons: Outpatient Physical Therapy, Requirements
- 37.40.1462 Home and Community-based Services for Elderly and Physically Disabled Persons: Speech Pathology and Audiology, Requirements
- 37.40.1463 Home and Community-based Services for Elderly and Physically Disabled Persons: Respiratory Therapy, Requirements
- 37.40.1464 Home and Community-based Services for Elderly and Physically Disabled Persons: Psycho-social Consultation, Requirements
- 37.40.1465 Home and Community-based Services for Elderly and Physically Disabled Persons: Behavioral Programming, Requirements
- 37.40.1466 Home and Community-based Services for Elderly and Physically Disabled Persons: Chemical Dependency Counseling, Requirements
- 37.40.1467 Home and Community-based Services for Elderly and Physically Disabled Persons: Cognitive Rehabilitation, Requirements

Rules 68 through 74 reserved



DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

- Rule 37.40.1475 Home and Community-based Services for Elderly and Physically Disabled Persons: Dietetic Services, Requirements
- 37.40.1476 Home and Community-based Services for Elderly and Physically Disabled Persons: Nutrition, Requirements
- 37.40.1477 Home and Community-based Services for Elderly and Physically Disabled Persons: Nursing, Requirements
- Rules 78 through 84 reserved
- 37.40.1485 Home and Community-based Services for Elderly and Physically Disabled Persons: Environmental Accessibility Adaptation, Requirements
- 37.40.1486 Home and Community-based Services for Elderly and Physically Disabled Persons: Personal Emergency Response Systems, Requirements
- 37.40.1487 Home and Community-based Services for Elderly and Physically Disabled Persons: Specialized Medical Equipment and Supplies, Requirements
- 37.40.1488 Home and Community-based Services for Elderly and Physically Disabled Persons: Nonmedical Transportation, Requirements

## Subchapter 14

## Home and Community-based Services

37.40.1401 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS AUTHORITY AND SCOPE OF PROGRAM

(1) The United States department of health and human services (HHS) has granted the department, through 42 CFR 441.300 through 441.310, the authority to establish a program of medicaid funded home and community-based services for persons who are elderly or who have physical disabilities and who would otherwise have to reside in and receive medicaid reimbursed care in a hospital or nursing facility.

(2) The department, in accordance with state and federal statutes and rules governing the provision of medicaid funded home and community-based services and any federal-state agreements governing the provision of medicaid funded home and community-based services and within the available funding appropriated for the program, may determine within its discretion:

(a) the types of services to be available through the program;

(b) the amount, scope and duration of the services available through the program;

(c) the categories of persons to be served through the program;

(d) the total number of persons who may receive services through the program;

(e) the total number of persons who may receive services through the program by category of eligibility, geographical area or specific case management team; and

(f) eligibility of individual persons for the program.

(3) There is no entitlement to eligibility for the program. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 02 through 05 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1406

37.40.1406 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SERVICES (1) The services available through the program are limited to those specified in this rule.

(2) The department may determine the particular services of the program to make available to a recipient based on, but not limited to, the following criteria:

(a) the recipient's need for a service generally and specifically;

(b) the availability of a specific service through the program and any ancillary service necessary to meet the recipient's needs;

(c) the availability otherwise of alternative public and private resources and services to meet the recipient's need for the service;

(d) the recipient's risk of significant harm or of death if not in receipt of the service;

(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; or

(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.

(4) Bases for denying a service to a person include, but are not limited to:

(a) the person requires more supervision than the service can provide;

(b) the person's needs, inclusive of health, can no longer be effectively or appropriately met by the service;

(c) access to the service, even with reasonable accommodation, is precluded by the person's health or other circumstances;

(d) a necessary ancillary service is no longer available; and

(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(5) The department may make program services for persons with intensive needs available to a recipient whom it determines, based on past medical history and current medical diagnosis, would otherwise require on a long term basis the level of care of an inpatient hospital or a rehabilitation service setting.



37.40.1406

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(6) The following services, as defined in these rules, may be provided through the program:

- (a) case management services;
- (b) homemaking;
- (c) personal assistance;
- (d) adult day health;
- (e) habilitation;
- (f) respite care;
- (g) personal emergency response systems;
- (h) nutrition services;
- (i) environmental accessibility adaptations;
- (j) nonmedical transportation;
- (k) outpatient physical therapy;
- (l) outpatient occupational therapy;
- (m) speech pathology and audiology;
- (n) respiratory therapy;
- (o) nursing;
- (p) psycho-social consultation; and
- (q) dietetic services;
- (r) adult residential care;
- (s) specially trained attendant care;
- (t) chemical dependency counseling;
- (u) cognitive rehabilitation;
- (v) comprehensive day treatment;
- (w) community residential rehabilitation;
- (x) supported living;
- (y) specialized medical equipment and supplies;
- (z) specialized child care for children with AIDS; and
- (aa) behavioral programming.

(7) Monies available through the program may not be expended on the following:

- (a) room and board; and
- (b) special education and related services as defined at 20 USC 1401(16) and (17).

(8) A service available through the program is not available to any extent that a service of another program is otherwise available to a recipient to meet the recipient's need for that service. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

## SENIOR AND LONG TERM CARE SERVICES

37.40.1407

37.40.1407 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: GENERAL REQUIREMENTS

(1) Services of the program may only be provided by or through a provider that is enrolled with the department as a medicaid provider or that is under contract with a provider the department is contracting with for home and community-based case management services.

(2) A facility providing services to a recipient must meet all licensing requirements including fire and safety standards.

(3) A provider of service must meet the requirements necessary for the receipt of reimbursement with medicaid monies.

(4) A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include:

(a) a spouse; and

(b) a natural or adoptive parent of a minor child.

(5) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



37.40.1408

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1408 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENROLLMENT (1) A person in order to be considered by the department for enrollment in the program, must be determined by the department to qualify for enrollment in accordance with the criteria in this rule.

(2) A person is qualified to be considered for enrollment in the program if the person:

(a) meets one of the following criteria:

(i) is 65 years of age or older; or

(ii) is certified as disabled by the social security administration but does not have a primary diagnosis of mental retardation or serious mental illness.

(b) is medicaid eligible;

(c) requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, 37.40.206 and 37.40.207.

(d) does not reside in a hospital or a nursing facility; and

(e) has needs that can be met through the program.

(3) The department considers for an available opening for services those persons who, as determined by the department:

(a) are actively seeking services;

(b) are in need of the services available;

(c) are likely to benefit from the available services;

and

(d) have a projected total cost of plan of care that is within the limits specified at ARM 37.40.1421.

(4) The department offers an available opening for services to the person, as determined by the department, who is most in need of the available services and most likely to benefit from the available services.

## SENIOR AND LONG TERM CARE SERVICES

37.40.1408

(5) Factors to be considered in the determinations of whether a person is in need of the available services and likely to benefit from those services and as to which person is most likely to benefit from the available services include, but are not limited to, the following:

- (a) medical condition;
- (b) degree of independent mobility;
- (c) ability to be alone for extended periods of time;
- (d) presence of problems with judgment;
- (e) presence of a cognitive impairment;
- (f) prior enrollment in the program;
- (g) current institutionalization or risk of institutionalization,
- (h) risk of physical or mental deterioration or death;
- (i) willingness to live alone;
- (j) adequacy of housing;
- (k) need for adaptive aids or environmental modifications;
- (l) need for 24 hour supervision;
- (m) need of person's caregiver for relief;
- (n) need, in order to receive services, of a waiver of the medicaid deeming financial eligibility requirement;
- (o) appropriateness for the person, given the person's current needs and risks, of services available through the program;
- (p) status of current services being purchased otherwise for the person; and
- (q) status of support from family, friends and community.

37.40.1408

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(6) A person enrolled in the program may be removed from the program by the department. Bases for removal from the program, include, but are not limited to, the following:

(a) a determination by the case management team that the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person's needs;

(b) the failure of the person to use the services as provided for in the plan of care;

(c) the behaviors of the person place the person, caregivers or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care;

(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;

(e) a determination by the case management team that the service providers necessary to the delivery of services as provided for in the plan of care are unavailable; and

(f) a determination that the total cost of plan of care is not within the limits specified at ARM 37.40.1421.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-131 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 09 through 14 reserved

NEXT PAGE IS 37-9205



## SENIOR AND LONG TERM CARE SERVICES

37.40.1415

37.40.1415 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS:

REIMBURSEMENT (1) Services available through the program are reimbursed as specified in this rule.

(2) The following services are reimbursed as provided in (3):

- (a) environmental accessibility adaptations;
- (b) homemaking;
- (c) adult day health;
- (d) habilitation;
- (e) personal emergency response systems;
- (f) nutrition;
- (g) psycho-social consultation;
- (h) nursing;
- (i) respiratory therapy;
- (j) dietetic services;
- (k) specially trained attendant care;
- (l) behavioral programming;
- (m) chemical dependency counseling;
- (n) cognitive rehabilitation;
- (o) comprehensive day treatment;
- (p) community residential rehabilitation;
- (q) supported living;
- (r) specialized medical equipment and supplies;
- (s) specialized child care for children with AIDS;
- (t) adult residential care;
- (u) respite care not provided by a nursing facility;

and

- (v) nonmedical transportation.

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

(a) the provider's usual and customary charge for the service; or

(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service as a service of the general medicaid program.

37.40.1415

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general medicaid program:

(a) personal assistance as provided at ARM 37.40.1105 and 37.40.1302;

(b) outpatient occupational therapy as provided at ARM 37.86.610;

(c) outpatient physical therapy as provided at ARM 37.86.610;

(d) speech therapy as provided at ARM 37.86.610; and

(e) audiology as provided at ARM 37.86.705.

(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.

(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.

(8) Reimbursement is not available for the provision of a service to a person that may be reimbursed through another program.

(9) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with medicaid monies.

(10) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 16 through 19 reserved



## SENIOR AND LONG TERM CARE SERVICES

37.40.1420

37.40.1420 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PLANS OF CARE (1) A plan of care is a written plan of supports and interventions based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.

(2) The services that a recipient may receive through the program and the amount, scope and duration of those services must be specifically authorized in writing through an individual plan of care for the person.

(3) The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least 6 months beginning with the date of the initial plan of care.

(4) Each plan of care is developed, reviewed and revised by the case management team.

(5) The case management team in developing the plan of care consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals and others who have knowledge of the recipient's needs.

(6) Each plan of care must include the following:

- (a) diagnosis, symptoms, complaints and complications indicating the need for services;
- (b) a description of the recipient's functional level;
- (c) objectives;
- (d) any orders for:
  - (i) medication;
  - (ii) treatments;
  - (iii) restorative and rehabilitative services;
  - (iv) activities;
  - (v) therapies;
  - (vi) social services;
  - (vii) diet; and
  - (viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care.
- (e) the specific services to be provided, the frequency of the services, and the type of provider to provide them;
- (f) the projected annualized costs of each service; and
- (g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.

37.40.1420

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(7) The case management team must provide a copy of the plan to the recipient.

(8) Plan of care approval is based on:

(a) completeness of plan;

(b) consistency of plan with screening criteria; and

(c) feasibility of service provision, including cost-effectiveness of plan as provided for in ARM 37.40.1421.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

## SENIOR AND LONG TERM CARE SERVICES

37.40.1421

37.40.1421 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COST OF PLAN OF CARE

(1) In order to maintain the program cost within the appropriated monies, the cost of plans of care for recipients may be limited by the department collectively and individually.

(2) The total annual cost of services for each recipient, except as provided in (3), may not exceed a maximum amount set by the department based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature.

(3) The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:

(a) the excess service need is short term and only a one time purchase is necessary;

(b) the excess service need is intensive services of 90 days or less which are necessary to:

(i) resolve a crisis situation which threatens the health and safety of the recipient;

(ii) stabilize the recipient following hospitalization or acute medical episode; or

(iii) prevent institutionalization during the absence of the normal caregiver;

(c) the excess service need is adult residential services; or

(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.

(4) The cost of services to be provided under a plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

(5) A cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 22 through 25 reserved



SENIOR AND LONG TERM CARE SERVICES

37.40.1426

37.40.1426 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NOTICE AND FAIR HEARING

(1) The department provides written notice to an applicant for and recipient of services when a determination is made by the department concerning:

- (a) financial eligibility;
- (b) level of care;
- (c) feasibility, including cost-effectiveness of services to the recipient; and
- (d) termination of recipient's eligibility for the program.

(2) The department provides a recipient of services with notice 10 working days before termination of services due to a determination of ineligibility.

(3) A person aggrieved by any adverse final determinations as listed in (1)(a) through (1)(d) or any adverse determinations regarding services in the plan of care may request a fair hearing as provided in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(4) Fair hearings will be conducted as provided for in ARM

37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 27 through 29 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1430

37.40.1430 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: CASE MANAGEMENT,  
REQUIREMENTS

(1) Case management is the planning for, arranging for, implementation of and monitoring of the delivery of services available through the program to a recipient.

(2) Case management services includes:

(a) developing a plan of care for a recipient;

(b) monitoring and managing a plan of care for a recipient;

(c) establishing relationships and contracting with service providers and community resources;

(d) maximizing a recipient's efficient use of services and community resources such as family members, church members and friends;

(e) facilitating interaction among people working with a recipient;

(f) prior authorizing the provision of all services;  
and

(g) managing expenditures.

(3) The case management team consists of a registered nurse and a social worker.

(4) The case management team must:

(a) function as directed by the department;

(b) assure that services provided to recipients are of appropriate quality and cost effective;

(c) provide case management services to no more than the number of persons specified by the department;

(d) manage expenditures within the allocated monies;  
and

(e) meet the department's reporting requirements.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 31 through 34 reserved



SENIOR AND LONG TERM CARE SERVICES 37.40.1435

37.40.1435 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT RESIDENTIAL CARE, REQUIREMENTS

(1) Adult residential care is the provision of supportive services to a recipient residing in an adult foster home, a residential hospice, or a personal care facility.

(2) Adult residential care may include:

(a) personal care services as specified at ARM 37.40.1101(1) through (5);

(b) homemaking as specified at ARM 37.40.1450;

(c) social activities;

(d) recreational activities;

(e) medication oversight; and

(f) assistance in arranging transportation for medical care.

(3) Adult residential care must provide for 24 hour on site response staff to meet scheduled or unpredictable needs of recipients and to provide supervision of recipients for safety and security.

(4) A recipient of adult residential care may not receive the following services through the program:

(a) personal assistance as specified at ARM 37.40.1447;

(b) homemaking services as specified at ARM 37.40.1450;

(c) environmental accessibility adaptation services as specified at ARM 37.40.1485.

(d) respite care as specified at ARM 37.40.1451;

(e) medical alert personal emergency response system as specified at ARM 37.40.1486; and

(f) nutrition as specified in ARM 37.40.1476. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rule 36 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1437

37.40.1437 HOME AND COMMUNITY-BASED SERVICES TREATMENT FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMMUNITY RESIDENTIAL REHABILITATION, REQUIREMENTS (1) Community residential rehabilitation is the provision of 24 hour care to a recipient in both a comprehensive day treatment setting as specified in ARM 37.40.1446 and in one of the following supervised residential settings: an adult foster home or a personal care facility.

(2) An entity providing community residential rehabilitation services, must provide services 24 hours a day for 7 days a week.

(3) An entity providing community residential rehabilitation must meet the requirements of ARM 37.40.1435 and 37.40.1446.

(4) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1438

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1438 COMMUNITY-BASED SERVICES FOR ELDERLY AND  
PHYSICALLY DISABLED PERSONS: SUPPORTED LIVING, REQUIREMENTS

(1) Supported living is the provision of supportive services to a recipient residing in an individual residence or in a group living situation. It is a comprehensive service designed to support a person with brain injury or other severe disability.

(2) Supported living services may include:

- (a) independent living evaluation;
- (b) service coordination;
- (c) 24 hour supervision of the person;
- (d) health and safety supervision;
- (e) homemaking services as specified at ARM 37.40.1450;
- (f) day habilitation as specified at ARM 37.40.1448;
- (g) habilitation aide as specified at ARM 37.40.1448;
- (h) behavioral programming as specified at 37.40.1465;
- (i) supported employment as specified at ARM

37.40.1448;

(j) prevocational training as specified at ARM

37.40.1448;

(k) nonmedical transportation as specified at ARM

37.40.1488; and

(l) specially trained attendants as specified at ARM

37.40.1449.

(3) An entity providing supported living services must meet the following criteria:

(a) be accredited by the commission on accreditation of rehabilitation facilities (CARF) or by the council on quality in the areas of integrated living, congregate living, personal, social and community services, community employment services and work services; and

(b) have 2 years experience in providing services to persons with physical disabilities.

(4) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 39 through 44 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1445

37.40.1445 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT DAY HEALTH (1) Adult day health is the provision of services to meet the health, social and habilitation needs of a recipient in settings outside the recipient's place of residence. An entity providing adult day health services must be licensed as provided at ARM 16.32.1001, et seq. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



37.40.1446

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1446 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMPREHENSIVE DAY TREATMENT, REQUIREMENTS (1) Comprehensive day treatment is the provision of therapeutic intervention to a recipient with brain injury on a week day basis in a non-residential setting. Comprehensive day treatment assists in reducing the dependency of the recipient and in facilitating the integration of the recipient into the community.

(2) Comprehensive day treatment services may include:

(a) cognitive rehabilitation as specified at ARM

37.40.1467;

(b) behavioral programming as specified at ARM

37.40.1465;

(c) chemical dependency counseling as specified at ARM

37.40.1466;

(d) therapeutic recreational activities;

(e) nutrition services as specified in ARM 37.40.1476;

(f) nonmedical transportation as specified at ARM

37.40.1488; and

(g) counseling.

(3) An entity providing comprehensive day treatment services, must provide services from 8 a.m. to 5 p.m. during the 5 working days of the week.

(4) An entity providing comprehensive day treatment services must be under the direction of an interdisciplinary team consisting of a licensed psychologist, a licensed neuropsychologist, a board certified physiatrist, therapists and other appropriate support staff.

(5) An entity providing comprehensive day treatment services must be accredited or in the process of becoming accredited by the commission on accreditation of rehabilitation facilities (CARF) as a community reentry program for persons with brain injury.

(6) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)



## SENIOR AND LONG TERM CARE SERVICES

37.40.1447

37.40.1447 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PERSONAL ASSISTANCE, REQUIREMENTS (1) Personal assistance is the provision of an array of personal care and other services to a recipient for the purpose of meeting personal needs in the home and the community. (2) Personal assistance services includes the provision of the following services:

(a) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308;  
(b) homemaking services as specified at ARM 37.40.1450;  
(c) supervision for health and safety reasons; and  
(d) nonmedical transportation as specified at ARM 37.40.1488.

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308.

(4) The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308 and 37.40.1315 govern the provision of personal assistance services. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1448

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES37.40.1448 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: HABILITATION,  
REQUIREMENTS

(1) Habilitation is the provision of intervention services designed for assisting a recipient to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully at home and in the community.

(2) Habilitation services may include:

- (a) residential habilitation;
- (b) day habilitation;
- (c) prevocational services;
- (d) supported employment; and
- (e) habilitation aide.

(3) Residential habilitation is habilitation provided in a community home for persons with physical disabilities.

(4) Day habilitation is habilitation provided in a day service setting.

(5) Prevocational services are habilitative activities that foster employability for a recipient who is not expected to join the general work force or participate in a transitional sheltered workshop within a year by preparing the recipient for paid or unpaid work. Prevocational services include teaching compliance, attendance, task completion, problem solving and safety.

(6) Supported employment is intensive ongoing support to assist a recipient who is unlikely to obtain competitive employment in performing work activities in a variety of settings, particularly work sites where nondisabled persons are employed. Supported employment service includes supervision, training and other activities needed to sustain paid work by a recipient.

(7) Habilitation aide is the assistance of an aide directed at fostering the recipient's ability to achieve independence in instrumental activities of daily living such as homemaking, personal hygiene, money management, transportation, housing and use of community resources. Habilitation aide services include conducting an assessment and the provision of training and teaching.

(8) An entity inclusive of its staff, providing habilitation services must be qualified generally to provide the services and specifically to meet each recipient's defined habilitation needs. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

## SENIOR AND LONG TERM CARE SERVICES

37.40.1449

37.40.1449 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS (1) Specially trained attendant care is the provision of supportive services to a recipient residing in their own residence.

(2) Specially trained attendant care services may include:

(a) personal assistance services as specified at ARM 37.40.1447; and

(b) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308.

(3) A person providing specially trained attendant care must be an employee of a medicaid enrolled personal assistance provider, trained in accordance with the department's training requirements by the provider and others to deliver the services that meet the specific needs of the recipient.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)



37.40.1450

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1450 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: HOMEMAKING,  
REQUIREMENTS

(1) Homemaking is the provision of general household activities or chore services to a recipient when the recipient is unable to manage the recipient's home or care for self or others in the home, or when another who is regularly responsible for these responsibilities is absent.

(2) Homemaking may include:

(a) household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing;

(b) social restorative services consisting of assistance which further a recipient's involvement with activities and other persons; and

(c) teaching services consisting of activities which improve a recipient's or family's skills in household management and social functioning.

(3) Homemaking services do not include the provision of personal care as specified at ARM 37.40.1101 and 37.40.1302.

(4) A person providing homemaking services must be:

(a) physically and mentally able to perform the duties required; and

(b) literate and able to follow written orders. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

## SENIOR AND LONG TERM CARE SERVICES

37.40.1451

37.40.1451 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPITE CARE,  
REQUIREMENTS

(1) Respite care is the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility.

(2) Respite care services may be provided only on a short term basis, such as part of a day, weekends or vacation periods.

(3) Respite care services may be provided in a recipient's place of residence or through placement in another private residence or other related community setting, a hospital, a nursing facility or a therapeutic camp.

(4) A person providing respite care services must be:

(a) physically and mentally qualified to provide this service to the recipient; and

(b) aware of emergency assistance systems.

(5) A person who provides respite care services to a recipient may be required by the case management team to have the following when the recipient's needs so warrant:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of common medications and related conditions of the recipient; and

(c) capability to administer basic first aid.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



37.40.1452

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1452 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALIZED CHILD CARE FOR CHILDREN WITH AIDS, REQUIREMENTS (1) Specialized child care for children with AIDS is the provision of day care, respite care, and other direct and supportive care to a recipient under 18 years of age who is HIV positive or has a diagnosis of AIDS and who, due to medical and other needs, cannot be served through traditional child care settings.

(2) A person providing specialized child care for children with AIDS services must be:

- (a) physically and mentally able to perform the duties;
- (b) aware of emergency assistance systems; and
- (c) literate and able to follow written orders.

(3) A person providing specialized child care for children with AIDS services may be required, if appropriate to the circumstances of the recipient, to have:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of the recipient's commonly needed medications and the conditions for which they are administered; and

(c) the capability to administer basic first aid.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 53 through 59 reserved

SENIOR AND LONG TERM CARE SERVICES

37.40.1461

37.40.1460 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS

(1) Outpatient occupational therapy services may include:

(a) occupational therapy services as specified at ARM 37.86.601; and

(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient occupational therapy services provided at ARM 37.86.601, 37.86.605, 37.86.606 and 37.86.610, govern the provision of outpatient occupational therapy services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1461 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT PHYSICAL THERAPY, REQUIREMENTS

(1) Outpatient physical therapy services may include:

(a) physical therapy services as specified at ARM 37.86.601; and

(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient physical therapy services at ARM 37.86.601, 37.86.605, 37.86.606 and 37.86.610, govern the provision of outpatient physical therapy services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1462

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1462 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPEECH PATHOLOGY AND AUDIOLOGY, REQUIREMENTS (1) Speech pathology and audiology services may include:

- (a) speech therapy services as defined at ARM 37.86.601;
- (b) audiology services as defined at ARM 37.86.702;
- (c) services for habilitative or maintenance purposes;
- (d) screening and evaluation with respect to speech and hearing functions;
- (e) comprehensive audiological assessment, as indicated by screening results, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;
- (f) assessments of the use of amplification;
- (g) provision for procurement, maintenance and replacement of hearing aids, as specified by a qualified audiologist;
- (h) comprehensive speech and language evaluation, as indicated by screening results, including appraisal of articulation, voice, rhythm and language;
- (i) participation in the continuing interdisciplinary evaluation for purposes of beginning, monitoring and following up on individualized habilitation programs; and
- (j) treatment services as an extension of the evaluation process, that include:
  - (i) direct counseling with a recipient;
  - (ii) consultation with appropriate persons involved with a recipient for speech improvement and speech education activities; and
  - (iii) work with an appropriate recipient to develop specialized programs for developing communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization and skills in expression, including improvement in articulation, voice, rhythm and language.

(2) The requirements for the delivery of speech therapy services at ARM 37.86.605 and 37.86.606 and for audiology services at ARM 37.86.701 and 37.86.702 govern the provision of speech pathology and audiology services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



## SENIOR AND LONG TERM CARE SERVICES

37.40.1464

37.40.1463 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPIRATORY THERAPY, REQUIREMENTS (1) Respiratory therapy is the provision of direct respiratory treatment, ongoing assessment of respiratory and medical conditions, equipment monitoring and upkeep, pulmonary education and respiratory rehabilitation.

(2) A certified respiratory therapy technician, as defined by the national board for respiratory care, may assist under the direct supervision of a registered respiratory therapist or physician who is responsible for and participates in the recipient's treatment program. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1464 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PSYCHO-SOCIAL CONSULTATION, REQUIREMENTS (1) Psycho-social consultation is consultation with providers and caregivers directly involved with a recipient and the development and monitoring of behavior programs.

(2) Psycho-social consultation services may include those services as specified at ARM 37.88.601 and 37.88.605.

(3) Requirements for the delivery of psychological services as specified at ARM 37.88.601 and 37.88.605 govern the provision of psycho-social consultation. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1990 MAR p. 2184, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1465

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES37.40.1465 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: BEHAVIORAL  
PROGRAMMING, REQUIREMENTS

(1) Behavioral programming is the continuous in-depth assessment on a short term basis of a recipient with brain injury.

(2) Behavioral programming services includes assessment, if appropriate, of the abilities and effectiveness of caregivers.

(3) A person providing behavioral programming services, must:

- (a) have a bachelor's degree;
- (b) be employed by a rehabilitation agency; and
- (c) be under the direct supervision of a licensed neurologist, board certified psychiatrist, or board certified physiatrist who has experience in working with persons with brain injury.

(4) This service is limited to 80 hours per plan of care year unless otherwise authorized by the department.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1466 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: CHEMICAL DEPENDENCY  
COUNSELING, REQUIREMENTS (1) Chemical dependency counseling is the provision of counseling to a recipient with a substance abuse problem by a certified chemical dependency counselor.

(2) Chemical dependency counseling services may be provided on an individual or group basis.

(3) A person providing chemical dependency counseling services for a recipient with brain injury must be a state certified chemical dependency counselor who has received training in the needs of persons with brain injury and the provision of brain injury services. The counselor must provide proof of such training in the form of a training certificate or diploma. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)



## SENIOR AND LONG TERM CARE SERVICES

37.40.1467

36.40.1467 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COGNITIVE REHABILITATION, REQUIREMENTS (1) Cognitive rehabilitation is the provision of therapeutic cognitive activities to meet the functional needs of a recipient with brain injury.

(2) Cognitive rehabilitation services may include:

(a) the reinforcement, strengthening, or reestablishment of previously learned patterns of behavior;

(b) the establishment of new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems; and

(c) training significant others to assist in meeting the functional needs of the recipient.

(3) A person providing cognitive rehabilitation services, must be:

(a) employed by a rehabilitation agency; and

(b) under the direct supervision of a licensed psychologist, licenced neuropsychologist, board certified neurologist, or board certified physiatrist who has experience in working with persons with brain injury. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 68 through 74 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1476

37.40.1475 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: DIETETIC SERVICES, REQUIREMENTS (1) Dietetic services are the management of a person's nutritional needs.

(2) Dietetic services may include evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education and dietetic research necessary for the management of a recipient's nutritional needs.

(3) Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1476 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NUTRITION, REQUIREMENTS

(1) Nutrition services are meals, congregate meals and home delivered meals as specified at ARM 37.41.302 including the meals on wheels program.

(2) The requirements for the delivery of nutrition services as specified at ARM 37.41.306 through 37.41.315 govern the provision of nutrition services.

(3) A full nutritional regimen of three meals a day may not be provided through this service. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1477

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1477 HOME AND COMMUNITY-BASED SERVICES FOR  
ELDERLY AND PHYSICALLY DISABLED PERSONS: NURSING,  
REQUIREMENTS

(1) Nursing is the provision of individual and continuous nursing care. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 78 through 84 reserved

## SENIOR AND LONG TERM CARE SERVICES

37.40.1485

37.40.1485 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENVIRONMENTAL ACCESSIBILITY ADAPTATION, REQUIREMENTS

(1) Environmental accessibility adaptations are modifications to a recipient's home designed to maintain or improve the recipient's ability to remain at home.

(2) Environmental accessibility adaptation services may include:

(a) modifications to a personal vehicle that allow the recipient to be more independent;

(b) the installation of specialized electrical and plumbing systems to accommodate necessary medical equipment and supplies;

(c) consultation regarding the appropriateness of an adaptation; and

(d) facilitation of the ability of a caregiver or service provider to maintain a recipient at home.

(3) An environmental accessibility adaptation must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) provide for the recipient's access to the home environment and increased independence and safety in the home;

(c) be reasonably expected to promote the recipient's functional ability or the ability of the caregiver to maintain the recipient at home;

(d) be the most cost effective adaptation among the adaptations that are available to meet the recipient's needs; and

(e) meet the 1980 specifications set by the American national standards institute.

(4) Environmental accessibility adaptation services do not include:

(a) general housing maintenance, including but not limited to plumbing, heating systems, or appliance repair; or

(b) measures to facilitate leisure time activities.

(5) The department may require review and approval by a consultant for certain types of environmental accessibility adaptations.

(6) A recipient may only receive any one environmental accessibility adaptation once unless the department specifically authorizes the repurchase of an adaptation.

(History: Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



37.40.1486

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.40.1486 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PERSONAL EMERGENCY RESPONSE SYSTEMS, REQUIREMENTS (1) A personal emergency response system is an electronic device or mechanical system used to summon assistance in an emergency situation.

(2) A personal emergency response system must be connected to a local emergency response unit with the capacity to activate emergency medical personnel.

(3) The provision of a personal emergency response system as a service does not include the purchase, installation or routine monthly charges of a telephone.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)



## SENIOR AND LONG TERM CARE SERVICES

37.40.1487

37.40.1487 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a recipient for the purpose of maintaining and improving the recipient's ability to reside at home and to function in the community.

(2) The provision of medical equipment and supplies services may include:

(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and

(b) the provision of supplies and care necessary to maintain a service animal.

(3) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) substantively meet the recipient's needs for accessibility, independence, health, or safety;

(c) be likely to improve the recipient's functional ability or the ability of a caregiver or service provider to maintain the recipient in the recipient's home; and

(d) be the most cost effective item that can meet the needs of the recipient.

(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.

(5) Specialized medical equipment and supplies services do not include:

(a) items used for leisure and recreational purposes only;

(b) items of clothing;

(c) basic household furniture; or

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit.

(6) A service animal is an animal trained to undertake particular tasks on behalf of a recipient that the recipient can not perform and that are necessary to meet the recipient's needs for accessibility, independence, health, or safety.

37.40.1487

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(7) A service animal does not include any of the following:

(a) pets, companion animals, and social therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

(8) Supplies necessary for the performance of a service animal may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal to meet the specific needs of the recipient. Supplies do not include food to maintain the service animals.

(9) Care necessary to the health and maintenance of a service animal may include, but is not limited to, veterinarian care, transportation for veterinarian care, license, registration, and where the recipient or recipient's primary care giver is unable to perform it, grooming.

(10) Certain items of medical equipment or supplies for short term use, as specified by the department, may be leased or rented instead of purchased.

(11) The department may require a consultation prior to the purchase of certain equipment and supplies. (History:

Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1488 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NONMEDICAL TRANSPORTATION, REQUIREMENTS (1) Nonmedical transportation is the provision to a recipient of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

(3) Nonmedical transportation providers must provide proof of:

- (a) a valid Montana driver's license;
- (b) adequate automobile insurance; and
- (c) assurance of vehicle compliance with all applicable federal, state and local laws and regulations.

(4) Nonmedical transportation services must be provided by the most cost effective mode.

(5) Nonmedical transportation services are available only for the transport of recipients to and from activities that are included in the individual plan of care. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)




*Drop  
off*®

**CARBONLESS  
FORM 3850**
**CARBON  
REQUIRED**
**PROPOSAL**  
TRIPLICATE

# PROPOSAL

No. \_\_\_\_\_

Date \_\_\_\_\_

Sheet No. \_\_\_\_\_

**Proposal Submitted To:**

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Phone \_\_\_\_\_

**Work To Be Performed At:**

Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Date of Plans \_\_\_\_\_  
Architect \_\_\_\_\_

We hereby propose to furnish the materials and perform the labor necessary for the completion of

All material is guaranteed to be as specified, and the above work to be performed in accordance with the drawings and specifications submitted for above work and completed in a substantial workmanlike manner for the sum of  
Dollars (\$ \_\_\_\_\_) 1.

with payments to be made as follows: \_\_\_\_\_

Any alteration or deviation from above specifications involving extra costs, will be executed only upon written orders, and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner to carry fire, tornado and other necessary insurance upon above work. Workmen's Compensation and Public Liability Insurance on above work to be taken out by

Respectfully submitted \_\_\_\_\_

Per \_\_\_\_\_

Note—This proposal may be withdrawn by us if not accepted  
within \_\_\_\_\_ days.

**ACCEPTANCE OF PROPOSAL**

The above prices, specifications and conditions are satisfactory and are hereby accepted. You are authorized to do the work as specified. Payment will be made as outlined above.

Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_





## HOME AND COMMUNITY BASED SERVICES PROGRAM SERVICE ANIMALS - CASE MANAGEMENT TEAM'S ROLE

1. Receive approved HCBS consumer referral from Mountain-Pacific Quality Health Foundation.
2. Develop plan of care with consumer noting choice for service animal. Notify regional program officer of this choice.
4. Provide consumer with informational packet on service animals. Assist consumer as needed.
5. Obtain from physician, occupational therapist, physical therapist, or other health care professional recommendation and assessment indicating consumer's ability to benefit from service animal.
6. Review consumer's responsibilities and obtain consumer's signature on Service Animal Stewardship Agreement DPHHS-MA-147.
7. Obtain consumer's signature on Confidential Information Release form.
8. Provide consumer with Approved Provider List for selection. Consumer will need to complete training organizations application process.
9. Send copy of physician, occupational therapist, physical therapist, or other health care professional assessment, plan of care, and statement of service to training organizations(s) for a bid.
10. Meet with Service Animal Selection Committee (Coordinator, Consumer, Regional Program Officer (RPO), and Case Management Team (CMT) member(s)). This committee will select the training organization. Enrollment of any training organization must be approved by the HCBS Program Manager.
11. Obtain RPO signature on Request for Prior Authorization (DPHHS-MA-149).
12. Coordinate pre-training assessment.
14. Coordinate evaluation process.
15. Monitor service animal placement to determine efficacy of working relationship.
16. Report any placement difficulties to the Service Animal Selection Committee members and the training organization for follow-up.

# THE HISTORY OF THE UNITED STATES

The history of the United States is a story of growth, struggle, and achievement. From the first settlers to the present day, the nation has evolved through various challenges and triumphs. The early years were marked by exploration and the establishment of colonies. The American Revolution led to the birth of a new nation, one that was founded on the principles of liberty and democracy. The 19th century was a period of westward expansion and the struggle for slavery. The Civil War was a pivotal moment in the nation's history, leading to the abolition of slavery and the preservation of the Union. The 20th century saw the rise of industrialization, the growth of the middle class, and the challenges of the Great Depression and World War II. The modern era is characterized by technological advancement, social change, and the ongoing pursuit of a better life for all Americans.

## HOME AND COMMUNITY BASED SERVICES PROGRAM SERVICE ANIMALS - CONSUMER'S ROLE

1. Apply for and become enrolled in HCBS Program, i.e.:
  - a. Be 65 years of age, or determined disabled by Disability Service Bureau;
  - b. Be financially eligible as determined by the County Office of Public Assistance; and
  - c. Meet the level of care criteria as determined by Mountain-Pacific Quality Health Foundation.
2. Develop a plan of care with the Case Management Team which includes a request for a service animal.
3. Obtain from physician, occupational therapist, physical therapist, or other health care professional recommendation indicating ability to benefit from service animal.
4. Sign Service Animal Stewardship Agreement, DPHHS-MA-147 .
5. Obtain Approved Provider Listing of Service Animal Training Organizations from the case management team.
6. Contact one or more training organization to determine if willing and able to provide service animal.
7. Select training organization(s) and inform the Case Management Team.
8. Obtain and complete training organization applications.
9. Make final selection with Service Animal Selection Committee.
10. Participate in pre-training assessment.
11. Complete training process with selected training organization.
12. Successfully pass evaluation with the service animal.
13. Meet all follow-up requirements of the training organization.
14. Report any problems with the service animal to the Case Management Team.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF THE HISTORY OF ARTS

THE HISTORY OF ARTS

THE HISTORY OF ARTS

THE HISTORY OF ARTS

THE HISTORY OF ARTS

THE HISTORY OF ARTS

Department of Public Health and Human Services	SECTION:  SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Directory of Assistive Technology Practitioners

Linda R. Botten, OTR/L, CHT  
Occupational Therapy  
206 N. Grand  
Bozeman, MT 59715  
Phone: (406) 586-3716  
Fax: (406) 586-4869  
E-mail: lbotten@montana.campus.mci.net

RESNA  
Alexandra Enders, OTR/L  
University of Montana  
52 corbin Hall  
Missoula, MT 59812  
Phone: (406) 243-2655  
Fax: (406) 243-2349  
E-mail: enders@selway.umn.edu

PLUK  
Roger Holt  
1500 N 30th St  
Billings, MT 59101  
Phone: (406) 657-2055  
Fax: (406) 657-2061  
E-mail: plukmt@wtp.net

Harrington Surgical Supply  
Michael Murray  
1125 Main St  
Billings, MT 59105  
Phone: (406) 248-9903  
Fax: (406) 248-8532

MonTech Program  
Rosemary Wagner  
634 Eddy Ave  
Missoula, MT 59812  
Phone: (406) 243-5676  
Fax: (406) 243-4730  
E-mail: wagner@selway.umn.edu

o o o





# CONSUMER RECYCLING AGREEMENT

I understand that Medicaid has purchased \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ for my use.

When I no longer have any need for this item, I will voluntarily agree to donate it to the case management team.

\_\_\_\_\_  
 Consumer Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Signature

\_\_\_\_\_  
 Date



Department of Public Health  
and Human Services

**SECTION:**

PROVISION OF SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Provider Eligibility

PROVIDER  
REQUIREMENTS:

Providers of Home and Community Based Services must meet the following criteria:

1. Be enrolled in the Montana Medicaid Program as a HCBS provider;
2. Meet the requirements in ARM 46.12.301 through 46.12.308 (Refer to Appendix 699-1);
3. Meet all pertinent state statutes and rules governing licensure and certification; and
4. Not be the recipient's spouse or parent if the recipient is a minor.

o o o





Department of Public Health and Human Services	SECTION:  PROVISION OF SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Provider Responsibilities

GENERAL RULE--All providers of Home and Community Based Services have the following responsibilities:

1. To retain medical records which fully disclose the extent and nature of services provided to recipients and which support fees charged or payments made;
2. To keep, establish and maintain accounting records that accurately identify, classify and summarize all funds and monies received and disbursed and provide an adequate audit trail;
3. To accept Medicaid payment as payment in full and never charge a recipient additional money unless it is to meet copayment requirements (Refer to HCBS 407 for a discussion of copayment);
4. To ensure the confidentiality of recipient records and other information related to recipients;
5. To make Medicaid records available for audit by authorized state and federal staff; and
6. To retain medical and financial records, supporting documents and all other records supporting services provided for six years and three months. If any litigation, claim or audit is started before the end of the six year and three month period, records must be retained until all litigation, claims or audit findings are resolved.

o o o



Department of Public Health  
and Human Services

**SECTION:**

PROVISION OF SERVICES

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Provider Enrollment

REQUIREMENT--All providers of Home and Community Based Services must be enrolled in Montana's Medicaid Program.

PROVIDER ENROLLMENT PROCEDURES--All requests for enrollment in the Medicaid Program must be made to Consultec. Enrollment forms can be requested in writing or by calling:

Consultec, Inc.  
P.O. Box 8000  
Helena, MT 59604  
1-800-624-3958 (In-State)  
406-442-1837

PROVIDER ENROLLMENT FORMS--The enrollment form must be completed in its entirety before the enrollment application can be processed by Consultec. (Refer to Appendix 699-2 for a copy of the HCBS Provider Enrollment Form.) Enrollment forms must be signed and approved by the Case Management Team (CMT) before the provider is enrolled. The CMT should indicate the appropriate procedure code(s), negotiated rate and effective date. Consultec must be notified of any changes to provider services and rates. Refer to Appendix 699-5 for a copy of the HCBS Provider Update Form that must be used to report provider changes to Consultec.

PROVIDER NUMBERS--In order to accurately track services to HCBS recipients, all providers enrolled in the Medicaid Home and Community Based Services Program are assigned a unique HCBS provider number. A provider may have more than one HCBS provider number. Each case management team must enroll a provider if the provider is providing services to one of their recipients. Claims will not be processed for HCBS recipients under an existing non-HCBS Medicaid provider number. Providers with HCBS

## SECTION:

PROVISION OF SERVICES

## SUBJECT:

Provider Enrollment

and non-HCBS numbers must separate their billing.

STATUS CHANGES--All status changes such as change in ownership, address, licensure, etc., must be immediately reported in writing to Consultec.

PROVIDER MANUAL--Consultec furnishes all providers with a Provider Manual upon enrollment. The Provider manual describes policy and procedures relating to billing for Medicaid services.

PROVIDER TRAINING--The Case Management Team must explain to the provider how to complete a HCFA 1500 claim form.

o o o

Department of Public Health  
and Human Services

SECTION:

PROVISION OF SERVICE

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Payment Requirements

PAYMENT FOR SERVICES--Payment for HCBS services is contingent on the following factors:

1. The recipient is eligible for Medicaid during the month in which the service is rendered;
2. The provider is eligible for Medicaid participation on the day the service is rendered and has agreed to accept the recipient and bill Medicaid;
3. The service is covered by Medicaid;
4. The recipient has not exceeded the limitations for a specific service;
5. A third party source has not already paid in full for the service;
6. Services are prescribed in the recipient's plan of care;
7. The HCBS case management team has approved the service; and
8. A clean claim is received by Consultec within 365 days of the dates of service.

o o o





Department of Public Health  
and Human Services

**SECTION:**

PROVISION OF SERVICE

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Payment Processing

REQUIREMENT--Payment for Home and Community Based Services must be made directly to the provider of service. No payment may be made to the recipient or any entity other than the provider of services unless otherwise specified by the Department.

HCBS case management teams may bill for environmental modifications and specialized equipment. CMTs may bill for other HCBS services provided by another entity to facilitate payment when a recipient goes out-of-state or for a one-time purchase or temporary service. When billing for a service provided by another entity, the CMT must obtain an invoice for the cost of the service.

CLAIM FORM--The provider requests payment from Medicaid by submitting a HCFA 1500 Claim Form to Consulatec. (Refer to Appendix 699-3). Providers must purchase their own supplies of the HCFA 1500 Claim Form. Claims may also be transmitted electronically.

CASE MANAGEMENT TEAM (CMT) APPROVAL--All Home and Community Based Services must be prior authorized by the CMT. The prior authorization number must be noted on the HCFA 1500 for all submitted charges. Refer to Appendix 699-6 and 699-7 for copies of the Prior Authorization form and Prior Authorization Change Request form.

PAYMENT DEADLINES--Provider's clean claims must be received by Consulatec no later than 365 days from the date services were provided in order to be reimbursed by Medicaid.

QUESTIONS ON CLAIMS--Questions about the filing of claims or payments should be referred to Consulatec Provider Relations, P.O. Box 8000, Helena, MT 59604. The in-state toll free number is 800-624-3958. The local number is 406-442-1837.

o o o



Department of Public Health  
and Human Services

SECTION:

PROVISION OF SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Reimbursement Methodology

GENERAL REQUIREMENT--Reimbursement for Home and Community Based Services not paid through other federal, state or locally funded programs shall be the lowest of the following:

1. The provider's usual and customary (billed) charges; or
2. The rate negotiated with providers by the Department or its designee.

NEGOTIATED RATES--Most of the rates for Home and Community Based Services are negotiated between the Case Management Team and the service provider. Providers must always bill the negotiated rate.

PROVIDER CHARGE FILE--When providers are enrolled in the program, negotiated rates are entered in MMIS for each type of service being billed. It is critical for the Case Management Team to advise Consultec of all negotiated rates when a provider initially enrolls and whenever there is a change in the negotiated rate. Refer to Appendix 699-5 for a copy of the HCBS Provider Update Form that can be used to report provider changes to Consultec.

PROCEDURE CODES AND RATES--For a complete listing of procedure codes and rates for Home and Community Based Services, refer to Appendix 699-4.

o o o





Department of Public Health  
and Human Services

## SECTION:

PROVISION OF SERVICES

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Licensure Requirements

Reference: ARM 46.12.301

REQUIREMENT: As a condition of participation in the Montana Medicaid Program, all providers must abide by all applicable state and federal statutes, regulations and rules governing licensure and certification.

INDEPENDENT  
PROVIDERS:

If an individual enrolls as an independent provider rather than an agency provider, the individual must provide a copy of the license certification or registration to Consultec. The Case Management Team must assure that the independent provider has workers' compensation coverage or is exempt by the Department of Labor and Industry for such coverage.

o o o



## MEDICAL SERVICES

46.12.302

## Sub-Chapter 3

## Provider Requirements

46.12.301 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers of service shall abide by all applicable state and federal statutes and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program, and all pertinent Montana statutes and rules governing licensure and certification. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

46.12.302 CONTRACTS (1) Providers shall enter into a written contract with the department delineating the services to be provided and reimbursement to be paid for duration, and referral. Natural persons who are providers need not enter such a contract.

(a) Providers under written contract may not obtain reimbursement for services which are not reimbursable to providers who are natural persons unless the services are unique to the specific provider. Reimbursement for these unique services shall be in accordance with the rules of the department.

(b) Providers under written contract shall not receive higher reimbursement rates for similar services than the rates allowed by the Montana medicaid program to providers, who are natural persons.

(c) Waivers of this written contract requirement may be granted to specific type providers at the discretion of the department if the provision of services and reimbursement rates for such services are governed specifically by the rules of the department.

(2) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare except as provided otherwise in these rules.

(3) Providers shall render services to an eligible medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

(a) No provider may deny services to any recipient because of the recipient's inability to pay a co-payment in ARM 46.12.204 or in ARM 46.17.121.

46.12.302

SOCIAL AND  
REHABILITATION SERVICES

(4) Providers shall not discriminate in the provision of service to eligible medicaid recipients on the grounds of race, creed, color, sex, national origin, or handicap. Providers shall comply with the department of health, education, and welfare regulations under Title VI and Title IX of the Civil Rights Acts, Public Law 93-112 (sections 504 and 505) and 49-1-101, 102 MCA; 49-2-101, 102 MCA; 49-2-202 MCA; 49-2-301 through 49-2-308 MCA; 49-2-401 through 49-2-404 MCA; 49-2-501 through 49-2-505 MCA; 49-2-601 MCA, as amended and all requirements imposed by or pursuant to the regulations implementing the statutes. (History: Sec. 53-2-201 and 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-131 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1987 MAR p. 900, Eff. 6/30/87; AMD, 1987 MAR p. 1116, Eff. 7/17/87; AMD, 1989 MAR p. 835, Eff. 6/30/89.)

NEXT PAGE IS 46-1159

46-1152

3/31/92

ADMINISTRATIVE RULES OF MONTANA



## MEDICAL SERVICES

46.12.303

- 46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers shall submit clean claims to medicaid within 12 months from the latter of:
- (a) the date of the service;
  - (b) the date retroactive eligibility was determined; or
  - (c) the date disability was determined.
- (2) For purposes of this section:
- (a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;
  - (b) for inpatient hospital services, date of service is the date of discharge;
  - (c) the date of submission to the medicaid program is the date the claim is stamped "received" by the department or it's designee;
  - (d) according to ARM 46.12.304(4) a provider may submit a bill to medicaid after 90 days of a prior submission to another third party insurer.
- (3) Claims must be submitted in accordance with this rule to be valid.
- (4) Except as provided in subsection (7) of this rule, all medicaid claims submitted to the department are to be submitted on a state claim form which is:
- (a) personally signed by that provider;
  - (b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or
  - (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.
- (5) All medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:
- (a) personally signed by the physician provider;
  - (b) personally signed by a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization; or
  - (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.



46.12.303

SOCIAL AND  
REHABILITATION SERVICES

(6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.

(7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under subsection (b) above.

(a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this subsection, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) The program shall pay 90 percent of all valid and proper claims within 30 days after receipt of said claim. Should the bureau contend that a claim is not valid or proper, the bureau shall inform the provider of the details of the contention within 30 days after receipt of the claim.

(a) The program shall pay 99 percent of all valid and proper claims within 90 days of receipt of the claims.

(b) The program shall make payment on all claims within 180 days of the receipt of the claim unless it determines payment to be improper under this chapter or applicable federal regulations.

(c) The department shall be entitled to promptly recover all payments erroneously or improperly made to a provider. At the option of the department, recoveries shall be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment shall be made in accordance with ARM 46.12.407.

## MEDICAL SERVICES

46.12.303

(10) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative.

(a) A provider may bill a recipient for the co-payments specified in ARM 46.12.204 and ARM 46.17.121.

(b) A provider may bill a recipient for services not covered by the medicaid program.

(c) A provider may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 46.17.119.

(11) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

(12) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(13) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(14) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination. (History: Sec. 53-2-201 and 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-131 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1981 MAR p. 530, Eff. 5/29/81; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 771, Eff. 7/31/81; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 379, Eff. 2/23/90; AMD, 1990 MAR p. 1586, Eff. 8/17/90; AMD, 1992 MAR p. 234, Eff. 2/14/92.)



46.12.304

SOCIAL AND  
REHABILITATION SERVICES

46.12.304 THIRD PARTY LIABILITY (1) No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except those services specified in subsection (6) below.

(2) For purposes of this section, the following definitions apply:

(a) A third party is defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. Indian health services is not a third party within the meaning of this definition.

(b) A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

(c) A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

(3) For known recipients, the provider shall use its same usual and customary procedures for inquiring about possible third party resources as is done for non-recipients.

(4) If the provider delivers to a recipient or a recipient's legal representative a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.

(a) The words "medicaid has assignment of, or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

(b) If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.

(5) If a provider learns of the existence of a known third party, that provider shall bill the third party prior to billing the department. If the department has knowledge of a known third party and the provider has not complied with subsections (6) or (7) below, the department shall deny payment of the services.

## MEDICAL SERVICES

46.12.304

(6) The department shall not deny payment of services solely because of the existence of a third party in the following circumstances:

(a) The primary diagnosis on the claim is for certain prenatal and preventive pediatric care as specified in the medicaid provider manual, copies of which may be obtained from the Montana Department of Social and Rehabilitation Services, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. The provider may bill the third party or the department in this circumstance.

(b) The third party is an insurer under a health insurance policy provided by the absent parent of a recipient and that health insurance is obtained or maintained as a result of an enforcement action taken by the child support enforcement division against that absent parent, if the following provisions are met:

(i) the provider submits evidence that the third party has been billed;

(ii) the claim is submitted to the department thirty (30) or more days beyond the date of service and in compliance with the timely filing rules in ARM 46.12.303(1);

(iii) the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; and

(iv) the claim is submitted directly to the third party liability unit (hereafter referred to as the TPL unit) within the department.

(c) The provider has billed the third party and has not received a reply from the third party, if the following provisions are met:

(i) the provider submits evidence of the date the third party was billed;

(ii) the claim is submitted ninety (90) or more days beyond the date established in (c)(i) and in compliance with the timely filing rules in ARM 46.12.303(1);

(iii) the provider certifies on the claim that notice of payment or denial has not been received; and

(iv) the provider submits the claim directly to the TPL unit.

(d) The claim is for services for which the department has been granted a waiver from use of the cost avoidance method and the department has chosen to use and continue to use that waiver, as identified in the medicaid provider manual.

(e) The provider is unable to obtain a valid assignment of benefits, if the following provisions are met:

(i) the provider submits documentation that it attempted to obtain assignment;

(ii) the provider certifies on the claim that assignment could not be obtained; and



46.12.304

SOCIAL AND  
REHABILITATION SERVICES

(iii) the provider submits the claim directly to the TPL unit.

(f) The third party is only a potential third party as defined in subsection (2)(c).

(7) Except as stated in subsection (8), the department shall pay its allowed amount for services, less any known third party payments for those services, for any claim where a known third party exists in the following circumstances:

(a) the claim is submitted under the provisions of subsection (6);

(b) the submitted claim clearly indicates the amount paid by the third party and includes whatever documentation is received regarding the payment from the third party; or

(c) the claim is submitted with a denial document which clearly shows that the third party denied the claim.

(8) For inpatient hospital claims where medicare part A benefits have been paid, the department's sole obligation shall be to pay the medicare part A deductible. For nursing home claims where medicare part A benefits have been paid, the department's sole obligation shall be to pay in accordance with ARM 46.12.1205(1)(a).

(9) In the event the provider receives a payment from a third party after the department has made payment, the provider shall refund to the department, within sixty (60) days of receipt of the third party payment, the lesser of the amount the department paid or the amount of the third party payment.

(a) The refund shall be made as described in ARM 46.12.303(2)(c) and shall indicate the name of the third party payor.

(b) The provider is entitled to retain any third party payments which exceed the medicaid allowed amount if all medicaid payments toward those services have been refunded to the department as required in this subsection.

(10) The department shall make no payment for services in those cases where, if the patient were not a medicaid recipient, the third party payment would constitute full payment with no further obligation owing from the recipient.

(11) For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party if the provider notifies the TPL unit of the identity of the third party and its name and address if known. The provider may keep its lien in place and receive payment from the third party. If payment is received from the third party, the provider must refund to the department as described in subsection (8).



## MEDICAL SERVICES

46.12.307

(12) A provider may not refuse to furnish services to a recipient based upon a third party's potential liability for the service. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; AMD, 1990 MAR p. 1719, Eff. 8/31/90.)

46.12.305 THIRD PARTY LIABILITY/ATTORNEYS' FEES SCHEDULE IS HEREBY REPEALED (History: Sec. 53-2-201 and 53-2-612 MCA; IMP, Sec. 53-2-612 MCA; NEW, 1980 MAR p. 1610, Eff. 6/13/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; REP, 1990 MAR p. 1609, Eff. 8/17/90.)

46.12.306 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization shall consider the type or nature of the service, the provider of the service, and the setting in which the service is provided.

(3) Experimental procedures are not a benefit of the program. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

46.12.307 PROVIDER RIGHTS (1) Although the department must necessarily limit reimbursable services, the department shall not interfere with a provider's right and responsibility to exercise professional judgment in rendering services.

(2) Providers shall have the right to manage their business affairs as they deem proper within the conditions and limitations imposed by these rules.

(3) A provider shall have the right to appeal any administrative decision which directly affects the rights or entitlements of the provider.

(4) A provider shall have the right to appeal on behalf of an applicant or recipient an administrative decision affecting the applicant's or recipient's rights or entitlements under the program.

(a) Notwithstanding subsection (4), nursing home and hospital care providers shall not have the right to appeal a denial of benefits to an applicant or recipient which was based upon the service provided not being medically necessary. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

46.12.308

SOCIAL AND  
REHABILITATION SERVICES

46.12.308 MAINTENANCE OF RECORDS AND AUDITING (1) All providers of service shall maintain records which fully disclose the extent and nature of the services provided to individuals receiving assistance under the Montana medicaid program, and which support the fee charged or payment sought for such services. These records shall be retained for a period of at least three years from the date on which the service was rendered.

(a) In maintaining financial records, providers shall employ generally accepted accounting methods. Generally accepted accounting methods are those approved by the national association of certified public accountants.

(b) The department shall have access to all medicaid recipient records so maintained and retained regardless of a provider's continued participation in the program.

(c) In the event of a change of ownership, the original owner must retain all required records unless an alternative method of providing for the retention of records has been established in writing and approved by the department.

(2) In addition to the recipient's medical records, any medicaid information regarding a recipient or applicant is confidential and shall be used solely for purposes related to the administration of the Montana medicaid program. This information shall not be divulged by the provider or his employees, to any person, group, or organization other than those listed below or a department representative without the written consent of the recipient or applicant.

(3) The department, the designated review organization, the legislative auditor, the department of health and human services, the department of revenue, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by this rule.

(a) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-141 MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80.)

46.12.309 MEDICAL ASSISTANCE MEDICAID PAYMENT (1) Medicaid will pay only for medical expenses:

(a) incurred by a person eligible for the medicaid program;

(b) for services provided for and to the extent provided for under the medicaid program;

(c) for which third party payment is not available;

(d) not used to meet the incurrment requirement at ARM 46.12.3801 and following rules for persons who are medically needy;



# MONTANA MEDICAID PROVIDER ENROLLMENT FORM

Montana Medicaid/Consultec  
Provider Enrollment Unit  
P.O. Box 8000  
Helena MT 59604

## SECTION A: FOR ALL PROVIDERS

Provider Name (Individual); or \_\_\_\_\_

Facility or Corporate Name: \_\_\_\_\_

Type of Provider (i.e. Dentist, Physician, Hospital, Nursing Home, Pharmacy, etc.): \_\_\_\_\_

### PAYMENT ADDRESS

(Used for mailing Medicaid payments)

### CORRESPONDENCE ADDRESS

(Used for mailing correspondence, notices and billing instructions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

City State Zip

City State Zip

County where services are provided: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Type of Ownership: ☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital Based ☐ HMO ☐ Group ☐ Clinic

Employer ID or Social Security Number: \_\_\_\_\_ (Medicaid payments will be reported as income to this number)

**Attach a copy of the organization's form IRS-P575 or, if not available, the W-9.**

## SECTION B - COMPLETE ALL ITEMS WHICH APPLY TO YOU

DEA Number: \_\_\_\_\_ NABP Number: \_\_\_\_\_

NPI: \_\_\_\_\_ CLIA Number: \_\_\_\_\_

License Number: \_\_\_\_\_ Original License Date: \_\_\_\_\_

(Out-of-state providers must attach a copy of professional licenses valid for all periods for which claims will be submitted.)

Medicare Provider Number: \_\_\_\_\_ Provider Fiscal Year End Date: \_\_\_\_\_

24 Hour Access Telephone Number (PASSPORT & HMO providers): (\_\_\_\_) \_\_\_\_\_ UPIN: \_\_\_\_\_

Specialties: \_\_\_\_\_

Primary

Secondary

Tertiary

Primary Specialty License Date: \_\_\_\_\_

## SECTION C - HOSPITALS & RESIDENTIAL TREATMENT CENTERS (RTC's)

Before payment can be made to your hospital or RTC for services provided to Montana Medicaid recipients, the following information must be provided. Please fill in the name and address of your Medicare intermediary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitals and RTC's must attach a complete copy of worksheets A, A8, C Part 1 and G2 of their most recent Medicare cost reports. Enrollment forms received without the cost report worksheets attached will be returned to the provider for completion.

## SECTION D - ELECTRONIC BILLING

Do you bill Medicaid electronically? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, do you bill directly, through an intermediary, or Pharmacy Point of Sale?

\_\_\_\_\_ Directly \_\_\_\_\_ Intermediary \_\_\_\_\_ Point of Sale (Pharmacy)

If directly, what is your Medicaid Electronic Submitter Number? \_\_\_\_\_

If an intermediary, provide the company's name. \_\_\_\_\_

**SECTION E - OWNERSHIP INFORMATION**Number of pages attached     

(Copy this page and complete for each person who has an ownership or control interest of 5% or more OR is an agent or managing employee in this provider entity)

1. Name (First Middle, Last, Jr., Sr., MD., D.O. etc.)		Date of Birth	
County/State/Country of Birth		Social Security No.	Medicaid ID No.
Are you the spouse, parent, child or sibling of other persons who have an ownership or control interest of 5% or more OR is an agent or managing employee in this provider entity? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, give name of person and relationship)			
Have you ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offence related to Medicare/Medicaid or any Federal agency or program? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			

2. Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services?

☐ No (Go to number 3) ☐ Yes If yes, fill in the following for each organization. Attach a copy of the organization's form IRS-P575 or, if not available, the W-9

Organization Legal Business Name	Employer ID No.	Medicaid ID No.
Organization Legal Business Name	Employer ID No.	Medicaid ID No.
Organization Legal Business Name	Employer ID No.	Medicaid ID No.
Organization Legal Business Name	Employer ID No.	Medicaid ID No.
Organization Legal Business Name	Employer ID No.	Medicaid ID No.

**3. Parent/Joint Venture Information**

Is your organization a subsidiary company or joint venture?

☐ No ☐ Yes

(If YES, fill in the following information about your parent company/joint business:)

Legal Business Name	Employer ID No.	Medicaid ID No.	
Business Street Address Line 1			
Business Street Address Line 2			
City	County	State	ZIP Code
Phone Number	Fax Number		

**DEFINITIONS**

**Ownership interest** means equity in the capital, the stock or the profits of the provider.

**Person with an ownership or control interest** means a person, partnership, corporation or other entity that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the provider or in an entity that has an indirect ownership interest in the provider.



**SECTION F - HOME AND COMMUNITY BASED PROVIDERS**

This section is used by the Case Management Team to designate negotiated services and rates for Home and Community Based Service Providers. Medicaid payment for home and community based services will be made only if the Case Management Team has identified the approved procedure codes and rates for the provider below.

PROCEDURE CODE	RATE	EFFECTIVE DATE
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

\_\_\_\_\_  
Authorizing Case Management Signature

\_\_\_\_\_  
C M T Name and Location

\_\_\_\_\_  
Date

**SECTION G - PROVIDER AGREEMENT & SIGNATURE**

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills Medicaid will have been previously furnished, amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply, as of December 1, 1991 and throughout the remaining term of this enrollment, with the applicable advance directive requirements of Section 1902(w) of the Social Security Act.

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (4-88) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or any activity connected with the provision of Medicaid services.



All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider further agrees to, in accordance with relevant laws, regulations and policies, including the 1996 Department Policy on Confidentiality of Client Information, protect the confidentiality of any material and information concerning an applicant for or recipient of Medicaid services.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error or other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively by the Department for the rate period.

The Provider agrees to notify Consultec at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought. I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Individual Practitioner Name

Individual Practitioner Signature

Date

**or for facilities and non-practitioner organizations:**

Authorized Representative Name Printed

Title/Position

Address:

Telephone Number

Authorized Representative Signature

Date

Completed enrollment forms are mailed to:

Consultec, Inc.  
Provider Enrollment Unit  
P.O. Box 8000  
Helena MT 59604

**Consultec Use Only**

Document # \_\_\_\_\_

If there are any questions about completing the enrollment form, please contact the Consultec provider relations staff at (406) 442-1837 or 800-624-3958 (in-state toll free).

Form **W-9**

(Rev. March 1994)

Department of the Treasury  
Internal Revenue Service**Request for Taxpayer  
Identification Number and Certification****Give form to the  
requester. Do NOT  
send to the IRS.**

Please print or type

Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below See instructions on page 2 if your name has changed.)

Business name (Sole proprietors see instructions on page 2.)

Please check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How To Get a TIN** below.

Social security number

--	--	--	--	--	--	--	--	--	--

OR

Employer identification number

--	--	--	--	--	--	--	--	--	--

**Note:** If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

List account number(s) here (optional)

**Part II For Payees Exempt From Backup Withholding (See Part II instructions on page 2)****Part III Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

**Certification Instructions.**—You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see **Part III instructions** on page 2.)

**Sign  
Here**

Signature ▶

Date ▶

Section references are to the Internal Revenue Code.

**Purpose of Form.**—A person who is required to file an information return with the IRS must get your correct TIN to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 to give your correct TIN to the requester (the person requesting your TIN) and, when applicable, (1) to certify the TIN you are giving is correct (or you are waiting for a number to be issued), (2) to certify you are not subject to backup withholding, or (3) to claim exemption from backup withholding if you are an exempt payee. Giving your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding.

**Note:** If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**What Is Backup Withholding?**—Persons making certain payments to you must withhold and pay to the IRS 31% of such

payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. The IRS tells the requester that you furnished an incorrect TIN, or
3. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable

interest and dividend accounts opened after 1983 only), or

5. You do not certify your TIN. See the Part III instructions for exceptions.

Certain payees and payments are exempt from backup withholding and information reporting. See the Part II instructions and the separate **Instructions for the Requester of Form W-9**.

**How To Get a TIN.**—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5**, Application for a Social Security Number Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4**, Application for Employer Identification Number (for businesses and all other entities), from your local IRS office.

If you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to get a TIN and give it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN.



**Note:** Writing "Applied For" on the form means that you have already applied for a TIN OR that you intend to apply for one soon.

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

## Penalties

**Failure To Furnish TIN.**—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil Penalty for False Information With Respect to Withholding.**—If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal Penalty for Falsifying Information.**—Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.**—If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

**Name.**—If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name, the last name shown on your social security card, and your new last name.

**Sole Proprietor.**—You must enter your individual name. (Enter either your SSN or E.N. in Part I.) You may also enter your business name or "doing business as" name on the business name line. Enter your name as shown on your social security card and business name as it was used to apply for your EIN on Form SS-4.

### Part I—Taxpayer Identification Number (TIN)

You must enter your TIN in the appropriate box. If you are a sole proprietor, you may enter your SSN or EIN. Also see the chart on this page for further clarification of name and TIN combinations. If you do not have a TIN, follow the instructions under **How To Get a TIN** on page 1.

### Part II—For Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For a complete list of exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form. If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed Form W-8, Certificate of Foreign Status.

### Part III—Certification

For a joint account, only the person whose TIN is shown in Part I should sign.

**1. Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts Considered Active During 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, Dividend, Broker, and Barter Exchange Accounts Opened After 1983 and Broker Accounts Considered Inactive During 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real Estate Transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other Payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

**5. Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, Cancellation of Debt, or IRA Contributions.** You must give your correct TIN, but you do not have to sign the certification.

### Privacy Act Notice

Section 6109 requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your

TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish.

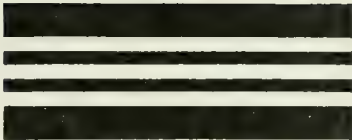
<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name, but you may also enter your business or "doing business as" name. You may use either your SSN or EIN.

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note:** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM										PICA <input type="checkbox"/>																																																																																																																																																																																																											
<b>1. MEDICARE</b> <input type="checkbox"/> <b>MEDICAID</b> <input type="checkbox"/> <b>CHAMPUS</b> <input type="checkbox"/> <b>CHAMPVA</b> <input type="checkbox"/> <b>GROUP HEALTH PLAN</b> <input type="checkbox"/> <b>FECA BLK LUNG</b> <input type="checkbox"/> <b>OTHER</b> <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					<b>1a. INSURED'S ID NUMBER</b> (FOR PROGRAM IN ITEM 1)																																																																																																																																																																																																																
<b>2. PATIENT'S NAME</b> (Last Name, First Name, Middle Initial)					<b>3. PATIENT'S BIRTH DATE</b> MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		<b>4. INSURED'S NAME</b> (Last Name, First Name, Middle Initial)																																																																																																																																																																																																														
<b>5. PATIENT'S ADDRESS</b> (No., Street)					<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		<b>7. INSURED'S ADDRESS</b> (No., Street)																																																																																																																																																																																																														
CITY		STATE			CITY		STATE																																																																																																																																																																																																														
ZIP CODE		TELEPHONE (Include Area Code)			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)																																																																																																																																																																																																														
<b>9. OTHER INSURED'S NAME</b> (Last Name, First Name, Middle Initial)					<b>10. IS PATIENT'S CONDITION RELATED TO</b>		<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>																																																																																																																																																																																																														
<b>a. OTHER INSURED'S POLICY OR GROUP NUMBER</b>					<b>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</b>		<b>a. INSURED'S DATE OF BIRTH</b>																																																																																																																																																																																																														
<b>b. OTHER INSURED'S DATE OF BIRTH</b> MM DD YY					<b>b. AUTO ACCIDENT?</b>		<b>b. EMPLOYER'S NAME OR SCHOOL NAME</b>																																																																																																																																																																																																														
<b>c. EMPLOYER'S NAME OR SCHOOL NAME</b>					<b>c. OTHER ACCIDENT?</b>		<b>c. INSURANCE PLAN NAME OR PROGRAM NAME</b>																																																																																																																																																																																																														
<b>d. INSURANCE PLAN NAME OR PROGRAM NAME</b>					<b>10d. RESERVED FOR LOCAL USE</b>		<b>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</b>																																																																																																																																																																																																														
							<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes return to and complete item 9 a-d</i>																																																																																																																																																																																																														
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b> <b>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										<b>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																																																																																											
<b>SAMPLE HCFA-1500 CLAIM FORM (12/90)</b> SIGNED _____ DATE _____										SIGNED _____																																																																																																																																																																																																											
<b>14. DATE OF CURRENT:</b> MM DD YY					<b>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</b> GIVE FIRST DATE MM DD YY					<b>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</b> FROM MM DD YY TO MM DD YY																																																																																																																																																																																																											
<b>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</b>					<b>17a. ID NUMBER OF REFERRING PHYSICIAN</b>					<b>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</b> FROM MM DD YY TO MM DD YY																																																																																																																																																																																																											
<b>19. RESERVED FOR LOCAL USE</b>										<b>20. OUTSIDE LAB?</b> \$ CHARGES																																																																																																																																																																																																											
										<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																											
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</b> (RELATE ITEMS 1 2 3 OR 4 TO ITEM 24E BY LINE)										<b>22. MEDICAD RESUBMISSION</b> CODE ORIGINAL REF NO																																																																																																																																																																																																											
1 _____ 3 _____																																																																																																																																																																																																																					
2 _____ 4 _____										<b>23. PRIOR AUTHORIZATION NUMBER</b>																																																																																																																																																																																																											
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A DATE(S) OF SERVICE</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th colspan="2">G DAYS OR UNITS</th> <th colspan="2">H EPSTD Family Plan</th> <th colspan="2">I EMG</th> <th colspan="2">J COB</th> <th colspan="2">K RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A DATE(S) OF SERVICE			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE		From	To																					MM	DD	YY	MM	DD	YY																	1																						2																						3																						4																						5																						6																										
A DATE(S) OF SERVICE			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE																																																																																																																																																																																																
From	To																																																																																																																																																																																																																				
MM	DD	YY	MM	DD	YY																																																																																																																																																																																																																
1																																																																																																																																																																																																																					
2																																																																																																																																																																																																																					
3																																																																																																																																																																																																																					
4																																																																																																																																																																																																																					
5																																																																																																																																																																																																																					
6																																																																																																																																																																																																																					
<b>25. FEDERAL TAX ID NUMBER</b>					<b>26. PATIENT'S ACCOUNT NO</b>					<b>27. ACCEPT ASSIGNMENT?</b> (For govt claims see back)					<b>28. TOTAL CHARGE</b>					<b>29. AMOUNT PAID</b>					<b>30. BALANCE DUE</b>																																																																																																																																																																																												
										<input type="checkbox"/> YES <input type="checkbox"/> NO					\$					\$					\$																																																																																																																																																																																												
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</b> INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										<b>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED</b> (If other than home or office)										<b>33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE &amp; PHONE #</b>																																																																																																																																																																																																	
SIGNED _____																				PIN# _____ GRP# _____																																																																																																																																																																																																	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Procedure Codes and Rates

SERVICE	CODE	RATE	MAXIMUM LIMIT	EFFECTIVE DATE
Adult Day Health	Z0506	Negotiated	\$ 7.00/hour	07/01/99
Adult Residential Foster Home, Personal Care Facility, Residential Hospice	Z0549	Negotiated	\$ 60.00/day	08/01/95
Case Management	Z0519		\$ 8.07/day	07/01/99
Case Management-Hourly	Z0575		\$ 55.00/hour	04/01/98
Chemical Dependency Counseling - Individual	Z0548	Negotiated	\$ 45.00/hour	08/01/95
Chemical Dependency Counseling - Group	Z0551	Negotiated	\$ 9.00/hour	08/01/95
Consumer/Family Intensive Support Service	Z0577	Negotiated	\$ 45.00/hour	07/01/00
Dietitian	Z0524	Negotiated	\$ 25.00/hour	01/01/87
Environmental Accessibility Adaptations	Z0515	Negotiated	\$4000.00/unit	10/01/86
Consultation	Z0515	Negotiated	\$4000.00/unit	03/01/01
Homemaker	Z0501	With wage plan	\$ 10.27/hour	07/01/00
		No wage plan	\$ 9.59/hour	07/01/00
Homemaker Chore Service	Z0553	Negotiated	\$ 250.00/unit	04/01/96
Nutrition (Meals)	Z0518	Negotiated	\$ 5.00/meal	10/01/86
Occupational Therapy	Z0531	Negotiated	\$ 15.00/hour	07/01/88
Personal Assistance Attendant	Z0573	With wage plan	\$ 3.22/15 min	11/01/00
		No wage plan	\$ 3.05/15 min	11/01/00
Self-Directed Personal Assistance Attendant		With wage plan	\$ 3.05/15 min	11/01/00
		No wage Plan	\$ 2.93/15 min	11/01/00
Personal Assistance Nurse Supervision	Z0574	With wage plan	\$ 3.22/15 min	11/01/00
		No wage plan	\$ 3.05/15 min	11/01/00
Self-Directed Personal Assistance Attendant		With wage plan	\$ 3.05/15 min	11/01/00
		No wage Plan	\$ 2.93/15 min	11/01/00

## SECTION:

APPENDIX

## SUBJECT:

Procedure Codes and Rates

SERVICE	CODE	RATE	MAXIMUM LIMIT	EFFECTIVE DATE
Personal Emergency Response System-Purchase/Installation	Z0516	Negotiated	\$ 800.00/unit	07/01/88
Personal Emergency Response System - Rental	Z0517	Negotiated	\$ 69.00/month	04/01/98
Physical Therapy	Z0529	Negotiated	\$ 15.00/hour	07/01/88
Private Duty Nursing, Over 4 Hours Shift	Z0526	Negotiated	\$ 20.62/hour	07/01/00
Private Duty Nursing Under 4 Hours Shift	Z0576	Negotiated	\$ 20.62/hour	07/01/99
Psychosocial Consultation	Z0527	Negotiated	\$ 40.00/hour	05/01/98
Respiratory Therapy	Z0525	Negotiated	\$ 25.00/hour	01/01/87
Respite Care - Facility	Z0511	Negotiated	\$ 360.00/day	09/01/95
1. Standard NF Rate if in NF 2. Standard AR rate if in ARCF 3. Negotiated rate for heavy care clients up to \$360.00 per day.				
Respite Care - Hourly	Z0512	With wage plan	\$ 9.26/hour	07/01/00
		No wage plan	\$ 8.58/hour	
Registered Nurse Supervision	Z0528		\$ 45.00/hour	01/01/87
Special Child Care for Children with AIDS	Z0550	Negotiated	\$ 11.51/hour	08/01/95
Specialized Medical Equipment & Supplies	Z0552	Negotiated	\$2000.00/unit	04/01/96
Consultation	Z0552	Negotiated	\$2000.00/unit	03/01/01
Specially Trained Attendant	Z0545	With wage plan	\$ 3.43/15 min	11/01/00
		No wage plan	\$ 3.26/15 min	11/01/00
Speech Therapy	Z0530	Negotiated	\$ 15.00/hour	07/01/88
Transportation - One Way Trip	Z0513	Negotiated	\$ 10.00/trip	10/01/86
Transportation - Miles	Z0514	Fixed	\$ .31/mile	01/01/97

## SECTION:

## APPENDIX

## SUBJECT:

## Procedure Codes and Rates

SERVICE	CODE	RATE	MAXIMUM LIMIT	EFFECTIVE DATE
<b>HABILITATION</b>				
Day Habilitation	Z0522	Negotiated	\$ 74.20/day	07/01/99
Habilitation Aide	Z0510	Negotiated	\$ 15.65/hour	07/01/99
Prevocational Services	Z0543	Negotiated	\$ 6.60/hour	06/01/95
Residential Habilitation	Z0523	Negotiated	\$ 122.73/day	07/01/00
Supported Employment Services	Z0544	Negotiated	\$ 25.00/hour	06/01/95
Transportation	Z0532	Negotiated	\$ 1.54/trip	07/01/92
<b>TRAUMATIC BRAIN INJURY (TBI)</b>				
Behavioral Programming	Z0547	Negotiated	\$ 22.00/hour	08/01/95
Cognitive Rehabilitation	Z0546	Negotiated	\$ 100.00/hour	08/01/95
Community Residential Rehabilitation	Z0542	Negotiated	\$ 540.00/day	05/01/95
Comprehensive Day Treatment	Z0541	Negotiated	\$ 440.00/day	03/01/95
Supported Living	Z0540	Negotiated	\$ 200.00/day	04/01/96

o o o



# Home and Community Based Services Provider Update Form

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

[ ] Address: \_\_\_\_\_  
\_\_\_\_\_

<u>A/D/C</u>	<u>Service</u>	<u>Procedure Code</u>	<u>Rate</u>	<u>Effective Date</u>
[ ]	_____	_____	_____	_____
[ ]	_____	_____	_____	_____
[ ]	_____	_____	_____	_____
[ ]	_____	_____	_____	_____
[ ]	_____	_____	_____	_____

OTHER:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
CMT Signature

\_\_\_\_\_  
Approver Number

\_\_\_\_\_  
Date

A - Add

D - Delete

C - Change



# THE HISTORY OF THE CITY OF BOSTON

BY

NAME	DATE	REMARKS	REMARKS
1	1780	1780	1780
2	1781	1781	1781
3	1782	1782	1782
4	1783	1783	1783
5	1784	1784	1784
6	1785	1785	1785
7	1786	1786	1786
8	1787	1787	1787
9	1788	1788	1788
10	1789	1789	1789
11	1790	1790	1790
12	1791	1791	1791
13	1792	1792	1792
14	1793	1793	1793
15	1794	1794	1794
16	1795	1795	1795
17	1796	1796	1796
18	1797	1797	1797
19	1798	1798	1798
20	1799	1799	1799
21	1800	1800	1800
22	1801	1801	1801
23	1802	1802	1802
24	1803	1803	1803
25	1804	1804	1804
26	1805	1805	1805
27	1806	1806	1806
28	1807	1807	1807
29	1808	1808	1808
30	1809	1809	1809
31	1810	1810	1810
32	1811	1811	1811
33	1812	1812	1812
34	1813	1813	1813
35	1814	1814	1814
36	1815	1815	1815
37	1816	1816	1816
38	1817	1817	1817
39	1818	1818	1818
40	1819	1819	1819
41	1820	1820	1820
42	1821	1821	1821
43	1822	1822	1822
44	1823	1823	1823
45	1824	1824	1824
46	1825	1825	1825
47	1826	1826	1826
48	1827	1827	1827
49	1828	1828	1828
50	1829	1829	1829
51	1830	1830	1830
52	1831	1831	1831
53	1832	1832	1832
54	1833	1833	1833
55	1834	1834	1834
56	1835	1835	1835
57	1836	1836	1836
58	1837	1837	1837
59	1838	1838	1838
60	1839	1839	1839
61	1840	1840	1840
62	1841	1841	1841
63	1842	1842	1842
64	1843	1843	1843
65	1844	1844	1844
66	1845	1845	1845
67	1846	1846	1846
68	1847	1847	1847
69	1848	1848	1848
70	1849	1849	1849
71	1850	1850	1850
72	1851	1851	1851
73	1852	1852	1852
74	1853	1853	1853
75	1854	1854	1854
76	1855	1855	1855
77	1856	1856	1856
78	1857	1857	1857
79	1858	1858	1858
80	1859	1859	1859
81	1860	1860	1860
82	1861	1861	1861
83	1862	1862	1862
84	1863	1863	1863
85	1864	1864	1864
86	1865	1865	1865
87	1866	1866	1866
88	1867	1867	1867
89	1868	1868	1868
90	1869	1869	1869
91	1870	1870	1870
92	1871	1871	1871
93	1872	1872	1872
94	1873	1873	1873
95	1874	1874	1874
96	1875	1875	1875
97	1876	1876	1876
98	1877	1877	1877
99	1878	1878	1878
100	1879	1879	1879

**STATE FISCAL YEAR 2001**  
**MEDICAID NURSING FACILITY**  
**REIMBURSEMENT RATES - FINAL**

09-Mar-01

03:44 PM

**SELECTED**  
**FY 2001**  
**MEDICAID**  
**RATE**

**CURRENT**  
**MEDICAID**  
**ID#**

**NAME OF**  
**FACILITY**

**CITY**

<b>FACNUM</b>	<b>FACILITY</b>	<b>CITY</b>	<b>MRTE</b>
31-4119	COMMUNITY NURSING HOME OF ANACONDA	ANACONDA	\$100.61
31-5224	FALLON COUNTY MEDICAL COMPLEX - NH	BAKER	\$101.83
31-0420	PRAIRIE VISTA MANOR	BIG SANDY	\$86.74
31-0518	BIG SANDY MEDICAL CENTER - LTC	BIG SANDY	\$99.84
31-0141	PIONEER MEDICAL CENTER	BIG TIMBER	\$98.34
31-2078	LAKEVIEW CARE CENTER	BIGFORK	\$97.92
31-0369	ASPEN MEADOWS	BILLINGS	\$106.47
31-2689	VALLEY HEALTH CARE CENTER	BILLINGS	\$102.95
31-0046	EVERGREEN BILLINGS HEALTH & REHABILITA	BILLINGS	\$94.34
31-2208	EAGLE CLIFF MANOR	BILLINGS	\$95.99
31-0206	ST. JOHN'S LUTHERAN HOME	BILLINGS	\$100.27
31-8760	WESTERN MANOR HEALTH CARE CENTER	BILLINGS	\$97.11
31-0193	PARKVIEW CARE CENTER	BILLINGS	\$95.58
31-2039	MOUNTAIN VIEW CARE CENTER	BOZEMAN	\$95.23
31-0466	EVERGREEN BOZEMAN HEALTH & REHABILITA	BOZEMAN	\$102.59
31-6836	GALLATIN REST HOME	BOZEMAN	\$105.91
31-1480	POWDER RIVER MANOR	BROADUS	\$97.88
31-0011	BLACKFEET NURSING HOME	BROWNING	\$92.07
31-0080	EVERGREEN BUTTE HEALTH & REHABILITATIO	BUTTE	\$99.51
31-0267	BUTTE CONVALESCENT CENTER	BUTTE	\$89.57
31-5731	CREST NURSING HOME	BUTTE	\$93.64
31-2858	LIBERTY COUNTY NURSING HOME	CHESTER	\$97.38
31-3014	SWEET MEMORIAL NURSING HOME	CHINOOK	\$100.16
31-1597	TETON MEDICAL CENTER - NH	CHOTEAU	\$103.04
31-8604	TETON NURSING HOME	CHOTEAU	\$95.16
31-7369	MCCONE COUNTY NURSING HOME	CIRCLE	\$98.54
31-0012	EVERGREEN CLANCY HEALTH & REHABILITAT	CLANCY	\$96.33
57-0219	MONTANA VETERAN'S HOME - NH	COLUMBIA FALLS	\$90.34
31-1844	STILLWATER COMMUNITY HOSPITAL-ECU	COLUMBUS	\$96.50
31-2052	BEARTOOTH MANOR	COLUMBUS	\$101.14
31-0232	PONDERA MEDICAL CENTER	CONRAD	\$102.73
31-0318	AWE KUALAWAACHE CARE CENTER	CROW AGENCY	\$98.56
31-0557	ROOSEVELT MEMORIAL MEDICAL CTR & NH	CULBERTSON	\$94.79
31-1129	GLACIER COUNTY MEDICAL CENTER - NH	CUT BANK	\$98.25
31-0250	COLONIAL MANOR OF DEER LODGE	DEER LODGE	\$89.33
31-1701	POWELL COUNTY MEMORIAL HOSP LTC	DEER LODGE	\$98.01
31-0471	PARKVIEW ACRES CONVALESCENT CENTER	DILLON	\$90.05
31-8981	DAHL MEMORIAL NURSING HOME	EKALAKA	\$94.27
31-0661	MADISON VALLEY MANOR	ENNIS	\$97.82
31-1350	MOUNTAIN VIEW MANOR GOOD SAMARITAN	EUREKA	\$92.34
31-4184	ROSEBUD HEALTH CARE CENTER - NH	FORSYTH	\$103.56
31-6550	MISSOURI RIVER MEDICAL CENTER	FORT BENTON	\$104.53
31-2572	VALLEY VIEW HOME	GLASGOW	\$97.92
31-0037	EASTERN MONTANA VETERAN'S HOME	GLENDIVE	\$86.58
31-6615	GLENDIVE MEDICAL CENTER - NH	GLENDIVE	\$103.23
31-0454	PARK PLACE HEALTH CARE CENTER	GREAT FALLS	\$95.29



31-0301	MISSOURI RIVER MANOR	GREAT FALLS	\$97.76
31-6771	BENEFIS SKILLED NURSING CENTER	GREAT FALLS	\$100.36
31-1623	THE DISCOVERY CARE CENTRE	HAMILTON	\$106.34
31-0167	VALLEY VIEW ESTATES HEALTH CARE CENTE	HAMILTON	\$98.52
31-2533	BIG HORN COUNTY MEMORIAL NH	HARDIN	\$97.95
31-2182	HERITAGE ACRES	HARDIN	\$97.63
31-7213	WHEATLAND MEMORIAL NURSING HOME	HARLOWTON	\$99.48
31-0323	NORTHERN MONTANA LONG TERM CARE	HAVRE	\$98.86
31-2143	BIG SKY CARE CENTER	HELENA	\$94.95
31-2247	ROCKY MOUNTAIN CARE CENTER	HELENA	\$98.16
31-0804	COONEY CONVALESCENT HOME	HELENA	\$106.10
31-0635	EVERGREEN HOT SPRINGS HEALTH & REHABI	HOT SPRINGS	\$96.69
31-1441	GARFIELD COUNTY HEALTH CENTER	JORDAN	\$97.72
31-3300	IMMANUEL LUTHERAN HOME	KALISPELL	\$94.23
31-0089	BRENDAN HOUSE	KALISPELL	\$99.13
31-2104	HERITAGE PLACE	KALISPELL	\$96.73
31-0114	EVERGREEN LAUREL HEALTH & REHABILITAT	LAUREL	\$94.39
31-8539	CENTRAL MONTANA NURSING HOME	LEWISTOWN	\$101.24
31-2260	VALLE VISTA MANOR	LEWISTOWN	\$103.17
31-2026	LIBBY CARE CENTER	LIBBY	\$96.81
31-0403	LIVINGSTON HEALTH AND REHABILITATION CE	LIVINGSTON	\$92.48
31-3872	PHILLIPS COUNTY GOOD SAMARITAN	MALTA	\$91.79
31-1831	HOLY ROSARY HEALTH CENTER	MILES CITY	\$104.39
31-2065	FRIENDSHIP VILLA CARE CENTER	MILES CITY	\$95.65
31-0258	HILLSIDE MANOR	MISSOULA	\$95.67
31-0180	THE VILLAGE HEALTH CARE CENTER	MISSOULA	\$99.18
31-1402	RIVERSIDE HEALTH CARE CENTER	MISSOULA	\$97.84
31-0029	EVERGREEN MISSOULA HEALTH & REHABILIT	MISSOULA	\$97.93
31-0336	GRANITE COUNTY MEMORIAL NH	PHILIPSBURG	\$98.23
31-1727	CLARK FORK VALLEY NURSING HOME	PLAINS	\$95.22
31-7434	SHERIDAN MEMORIAL NURSING HOME	PLENTYWOOD	\$94.89
31-0622	EVERGREEN POLSON HEALTH & REHABILITAT	POLSON	\$96.69
31-4626	NORTHEAST MONTANA HEALTH SERVICES, IN	POPLAR	\$94.92
31-1935	BEARTOOTH HOSPITAL HEALTH CENTER	RED LODGE	\$91.33
31-2117	CEDAR WOOD VILLA	RED LODGE	\$97.03
31-0216	WEST SIDE CARE CENTER	RONAN	\$90.85
31-0765	ST. LUKE COMMUNITY NURSING HOME	RONAN	\$99.47
31-0882	ROUNDUP MEMORIAL NURSING HOME	ROUNDUP	\$99.67
31-8682	DANIELS MEMORIAL NURSING HOME	SCOBAY	\$93.78
31-5666	MARIAS CARE CENTER	SHELBY	\$105.88
31-3963	TOBACCO ROOT MOUNTAINS CARE CENTER	SHERIDAN	\$98.58
31-0245	SIDNEY HEALTH CENTER	SIDNEY	\$107.62
31-0609	BITTERROOT VALLEY LIVING CENTER	STEVENSVILLE	\$105.26
31-1103	MINERAL COUNTY NURSING HOME	SUPERIOR	\$97.36
31-3456	PRAIRIE COMMUNITY NURSING HOME	TERRY	\$98.17
31-0726	BROADWATER HEALTH CENTER NH	TOWNSEND	\$97.50
31-1467	MOUNTAINVIEW MEMORIAL NH	WHITE SULPHUR	\$99.56
31-0233	COLONIAL MANOR OF WHITEFISH	WHITEFISH	\$100.48
31-8916	NORTH VALLEY HOSPITAL AND ECC	WHITEFISH	\$96.86
31-3378	WIBAUX COUNTY NURSING HOME	WIBAUX	\$99.09
31-0349	FAITH LUTHERAN HOME	WOLF POINT	\$97.04
# of Rows 97	TOTAL		
	AVERAGE		\$97.80
	WEIGHTED AVERAGE		

Department of Public Health  
and Human Services

**SECTION:**

PREADMISSION SCREENING

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Screening Requirements

DEFINITION--Preadmission screening means a medical, psychological and social evaluation completed by the Mountain Pacific Quality Health Foundation which results in a determination of whether the applicant for HCBS meets level of care requirements.

PURPOSE--The purpose of preadmission screening for Home and Community Based Services (HCBS) is to assure the necessity and appropriateness of admissions to this program.

REQUIREMENT--All Medicaid applicants and recipients must have a preadmission screening completed by the Foundation and be determined to meet the appropriate level of care requirements before HCBS will be authorized.

NOTIFICATION--The Foundation will notify the applicant of the results of the screening by completing the DPHHS-MA-61, "Screening Determination", within 10 days of the screening. The Foundation will also send a copy of the DPHHS-MA-61 to the Eligibility Staff in the county where the individual is applying for Medicaid benefits and the HCBS Case Management Team with which the applicant intends to enroll. (Refer to Appendix 799-1 for a copy of the DPHHS-MA-61).

o o o





Department of Public Health  
and Human Services

**SECTION:**

PREADMISSION SCREENING

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Screening Referral Procedures

REFERRALS--Referrals for screening should be made to the Mountain Pacific Quality Health Foundation.

The Foundation will complete a phone screen to determine level of care. The Foundation will also complete a Level I Screen at that time. A copy of the screens are forwarded to the Case Management Team upon completion of the screening if the individual chooses to be referred to the Home and Community Based Services Program.

RESPONSE TIME--As a general rule, screenings will be conducted within three working days of referral.

When decisions must be made regarding response time for screening, the priorities are:

1. Individuals in hospitals awaiting placement in the HCBS Program;
2. Individuals in the community who are at risk of institutionalization;
3. Individuals in the community or in nursing homes who are not at risk. This would include individuals who have a secure environment in the community with family support, or who have been in a nursing home for more than six months as private pay and are applying for Medicaid to continue their nursing home stay.

o o o



Department of Public Health  
and Human Services

**SECTION:**

PREADMISSION SCREENING

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Reevaluations

DEFINITION--A reevaluation is a redetermination of level of care of individuals enrolled in the Home and Community Based Services program by the Mountain Pacific Quality Health Foundation.

PROTOCOL-Level of care screens for the annual reevaluation as of July 1, 1999 are no longer mandatory. Case management teams may request a reevaluation by the Foundation at anytime the team believes the recipient no longer meets level of care. If a recipient no longer meets level of care, they will receive a temporary approval to allow for discharge planning.

o o o



## SCREENING DETERMINATION

Name of Applicant _____	Mountain Pacific Quality Health Foundation 400 North Park Avenue Helena, MT 59601
Street Address _____	Phone: 1-800-219-7035/443-0320
City and Zip Code _____	Social Security No. _____
	Fax: 1-800-413-3890/443-4585

## SCREENING DETERMINATION:

On \_\_\_\_\_ you were screened to determine if you are in need of Long Term Care Services. Long Term Care Services include nursing facility care and the Home and Community Based Services program. The decision of the screening professional is:

\_\_\_\_\_ Long Term Care Services **ARE NOT** required and will **NOT** be paid by Medicaid. If Medicaid payment is currently being made for Long Term Care Services, it will terminate on \_\_\_\_\_. You may be eligible for other Medicaid Services. Contact your local Office of Human Services for further information.

\_\_\_\_\_ Long Term Care Services **ARE** required and Medicaid **WILL** pay **IF YOU ARE FINANCIALLY ELIGIBLE**. Contact your local Office of Human Services regarding financial eligibility. For Home and Community based Services, Medicaid payment is dependent upon the availability of a slot.

\_\_\_\_\_ A temporary placement has been approved for Long Term Care Services. This approval expires on \_\_\_\_\_. You will be rescreened before the expiration date.

If you have not entered Long Term Care Services (Nursing Facility or Home and Community Based Services) and determined financially eligible within 60 days of the screening date, this screening determination is no longer valid.

## RECIPIENT'S CHOICE OF LONG TERM CARE PROGRAM:

Nursing Facility \_\_\_\_\_

Home &amp; Community Based Services: \_\_\_\_\_

Initial \_\_\_\_\_ Reevaluation \_\_\_\_\_

Effective Date: \_\_\_\_\_

(See back of page for further explanation of effective date.)

If you are financially eligible for Long Term Care Services, you may choose to apply for services in a nursing facility or through the Home and Community Based Services Program. If you have any questions regarding this action or if you have additional facts to present, please write or telephone the Mountain Pacific Quality Health Foundation (address, phone above).

Screened by \_\_\_\_\_

Name \_\_\_\_\_

Position \_\_\_\_\_

Date \_\_\_\_\_

LEGAL BASIS for ACTION

## LONG TERM CARE

ARM 46 12 1102-1104, 46 12 1301 1305 1306 1308  
42 C.F.R. 4456 260, 270, 271 331-338, 360 370, 371, 372, 431-  
438, 42 C.F.R. 483 12 Part 483 Subparts C and I

## REQUEST FOR FAIR HEARING

IF YOU DISAGREE WITH THIS DETERMINATION, YOU MAY REQUEST A FAIR HEARING. PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR FURTHER INFORMATION ON THE FAIR HEARING PROCESS.

I request a fair hearing for these reasons: \_\_\_\_\_

I have an attorney: [ ] YES [ ] NO

My attorney's name is: \_\_\_\_\_

Attorney's address: \_\_\_\_\_

Attorney's phone number: \_\_\_\_\_

(Claimant or Authorized Representative)

(Phone)

(Date)

To request a fair hearing complete, sign and mail the white copy of this notice to: Hearing Officer, P.O. Box 202951, Helena, MT 59620.

cc: County \_\_\_\_\_

cc: Provider \_\_\_\_\_



Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, disability, sex or marital status.

If you feel that you have been discriminated against, you may contact the Department of Public Health and Human Services for information on how to file a complaint.

### **IMPORTANT**

If you disagree with the determination stated on this form you may request a fair hearing before a hearing officer of the Board of Public Assistance.

Under certain circumstances you may continue to receive services during the period of your appeal. A request for continuation of services must be made prior to the date given in the notice of the change in or termination of your services. If you are interested in continuing to receive services during the period of your appeal, you must contact one of the regional offices immediately to request continuation of services. If you lose your appeal, you will be fiscally responsible for services delivered during the appeal process.

A request for fair hearing must be made in writing within 90 days of the mailing date of this notice. You may use the "Request for Fair Hearing" section on the front section of this form to make your request. A request for fair hearing must be directed to:

Hearing Officer  
P.O. Box 202951  
Helena, MT 59620

If you need assistance in preparing a request for fair hearing you may contact one of the regional offices listed below.

Prior to the fair hearing, a program officer for the Department will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity for you to informally present your case and for the Department to reconsider the matters that you are appealing.

The fair hearing is a process in which the parties formally present their legal arguments and evidence in support of their positions on the matters at issue. The decision of the hearing officer is made based on the evidence presented at hearing and upon the governing federal and state laws, regulations and policies. The decision of the hearing officer may be appealed to the Board of Public Assistance. The Board of Public Assistance reviews the matters at issue as presented before the hearing officer. This appeal does not involve another hearing. The decision of the hearing officer or the Board of Public Assistance resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.

### **REGIONAL PROGRAM OFFICERS**

Regional Program Officer  
P.O. Box 2357  
Kalispell, MT 59903  
Phone: 755-5420

Flathead, Lake, Lincoln,  
Sanders

Regional Program Officer  
1824 10th Ave S  
Great Falls, MT 59403  
Phone: 453-8902  
453-8975

Blaine, Cascade, Choteau,  
Fergus, Glacier, Hill,  
Judith Basin, Liberty, Petroleum,  
Phillips, Pondera, Teton,  
Toole

Regional Program Officer  
1610 S 3rd W Suite 202  
Missoula, MT 59801  
Phone: 329-5426

Missoula, Mineral, Ravalli

Regional Program Officer  
1211 Grand Avenue  
Billings, MT 59102  
Phone: 247-2650

Big Horn, Carbon,  
Golden Valley, Musselshell,  
Stillwater, Treasure,  
Wheatland, Yellowstone

Regional Program Officer  
3075 N Montana Ave  
Helena, MT 59601  
Phone: 444-1707

Broadwater, Jefferson,  
Lewis & Clark, Meagher,  
Powell, MT State Hospital  
Long Term Care Unit

Regional Program Officer  
207 West Bell  
Glendive, MT 59330  
Phone: 377-6252

Carter, Custer, Daniels,  
Dawson, Fallon, Garfield,  
McCone, Powder River,  
Prairie, Richland, Roosevelt,  
Rosebud, Sheridan, Valley,  
Wibaux

Regional Program Officer  
700 Casey  
Butte, MT 59701  
Phone: 496-4989

Beaverhead, Deer Lodge,  
Granite, Silver Bow

Regional Program Officer  
202 South Black  
Bozeman, MT 59715  
Phone: 586-4089

Gallatin, Madison, Park  
Sweetgrass

### **EXPLANATION OF EFFECTIVE DATE**

#### **Nursing Facilities:**

Date of financial eligibility will be determined by the local human service office. Actual effective date for Medicaid reimbursement for nursing facility services will be the later of these two dates: 1) effective date listed on the front; or 2) the date of financial eligibility.

#### **Home and Community Based Services:**

If you are on a waiting list for Home and Community Based Services, enrollment will be dependent upon the availability of slots. If enrollment is more than 60 days from the screening date listed on the front, a new screen is required.

Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Case Management Requirements

REQUIREMENT--The Department contracts with Case Management Teams to provide case management services. Case management providers may be public, private or nonprofit organizations such as a County Welfare Department, a County Health Department, a Home Health Agency or any other organization which has the resources to meet program requirements.

ADMINISTRATIVE SEPARATENESS--An agency who provides case management services and plans to provide other Home and Community Based Services (HCBS) must assure that the case management team is administratively separate. This means the case management team must be able to make independent decisions regarding the use of any and all available service providers and monitor the quality of services provided. This is to assure the case management team can arrange for services according to the recipient's need and choice of providers and is under no mandate to use the agency's services over other available service providers. The team must assure that services provided are necessary, of appropriate quality and least costly and should have no vested interest in who is selected to provide the services.

At the beginning of each contract period, the case management agency must provide the Department with a statement describing which HCBS will be provided in addition to case management. The statement includes the type of services provided, who bills for the services and the reimbursement rates for each service. This does not include HCBS provided by subcontractors.

## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Case Management Requirements

The statement should also include an assurance of the following:

1. The direct provision of these services is necessary to assure an adequate supply of services;
2. The services are of comparable quality to other services in the area; and
3. The services are included in a Plan of Care which considers recipient choice, types of services needed and geographical area.

ENROLLMENT LIMITS--The Case Management Team shall provide case management services to no more than the number of persons allowed by the Department.

CONTRACT TERMS AND CONDITIONS--The time period for contracts is three years with the Department option for three consecutive twelve month extensions. The current Case Management Team contracts cover the period July 1, 1998 through June 30, 2002.

o o o

Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Case Management Team Require-  
ments

TEAM COMPOSITION--Case Management Teams consist of the following:

- A Registered Nurse licensed to practice in the State of Montana;
- A Social Worker; and
- Appropriate Clerical Staff.
- Staff must be sufficient to appropriately meet the needs of the CMT's HCBS recipients.

TEAM MEMBER REQUIREMENTS--

1. The registered nurse must:
  - a. Have a Bachelor's Degree in nursing and three years of professional nursing experience, including one year of supervisory or administrative experience, or an equivalent combination of education and experience. For this program, equivalency of education and experience is: a registered nurse with three years of professional nursing experience, including two years of supervisory or administrative experience, plus two years of long-term care experience;
  - b. Be licensed to practice in the State of Montana;
  - c. Have knowledge of case management methods, procedures and practices;
  - d. Have knowledge of the application of diagnostic and crisis intervention skills;



## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Case Management Team Requirements

- e. Have knowledge of the problems and needs of long-term care recipients; and
  - f. Have the ability to:
    - Promote recipient's self-determination;
    - Assess recipient needs;
    - Develop and implement individual plans of care and determine the services most appropriate to fit each individual recipient within specified cost limits;
    - Monitor service delivery including cost of services provided;
    - Evaluate service effectiveness;
    - Re-assess continuing recipient need; and
    - Provide guidance to assist recipients in utilizing services effectively and appropriately.
2. The social worker must have:
- a. A Bachelor's Degree in social work or a related behavioral science and one year experience in a health care setting;
  - b. Knowledge of case management methods, procedures and practices;
  - c. Knowledge of the application of diagnostic and crisis intervention skills;



## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Case Management Team Requirements

- d. Knowledge of the problems and needs of long-term care recipients; and
- e. The ability to:
  - Promote recipient's self-determination;
  - Assess recipient needs;
  - Develop and implement a plan of care with respect to social and other nonmedical covered services;
  - Monitor service delivery;
  - Evaluate service effectiveness;
  - Re-assess continuing recipient need;
  - Provide guidance to assist recipients in utilizing community services effectively and appropriately; and
  - Identify and participate in the development or improvement of community resources as related to finding alternatives for long-term care.

o o o



Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Service Areas

CASE MANAGEMENT TEAM SITES--The core sites where Case Management Teams are located and the counties they are authorized to serve are:

CORE SITES

COUNTIES SERVED

Billings

Yellowstone, Big Horn,  
Carbon, Rosebud,  
Stillwater, Sweetgrass,  
Treasure

Bozeman

Gallatin, Madison,  
Meagher, Park

Butte

Silverbow, Beaverhead,  
Deer Lodge, Granite,  
Powell

Great Falls

Cascade, Blaine,  
Chouteau, Glacier, Hill,  
Liberty, Pondera, Teton,  
Toole

Helena

Lewis & Clark,  
Broadwater, Jefferson

Kalispell

Flathead, Lake, Lincoln,  
Sanders

Lewistown

Fergus, Golden Valley,  
Judith Basin,  
Musselshell, Petroleum,  
Phillips, Wheatland

Miles City

Custer, Carter, Dawson,  
Fallon, Garfield, Powder  
River, Prairie, Rosebud,  
Wibaux

## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Service Areas

Missoula-Elderly

Missoula, Mineral,  
Ravalli

Missoula-Disabled

Missoula, Mineral,  
Ravalli

Sidney

Richland, Daniels,  
Dawson, McCone,  
Roosevelt, Sheridan,  
Valley

o o o

Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Record Requirements

GENERAL REQUIREMENT--Case Management Teams must maintain a record for all recipients.

COMPOSITION OF RECORD--The case management record must include at least the following forms:

- Initial Screening Results;
- Referral Forms;
- Intake Sheets;
- Plans of Care;
- Plan of Care Cost Sheets;
- Progress Notes;
- Discharge Sheets;
- Psychosocial Summary;
- Reevaluation Forms;
- Amendment Forms; and
- Prior Authorization Forms.

o o o





Department of Public Health  
and Human Services

## SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

SECTION RESERVED FOR FUTURE USE

o o o



Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Reporting Requirements

PURPOSE--Reporting requirements for Case Management Teams were developed to provide a single source of reference for all reporting activities and replace all previously issued instructions. CMTs can supplement these requirements by reporting additional information for internal purposes; however, these requirements are the only mechanism for collecting and reporting this information to the Department of Public Health and Human Services (DPHHS).

The required reporting formats include the Intake Sheet, (DPHHS-MA-136), Discharge Sheet (DPHHS-MA-137) and the Case Management Evaluation Summary (see HCBS 899-2). Refer to instructions for each form in HCBS 899 appendix.

USE OF THE REPORTS--The reports are used to:

1. Collect and report data for federal requirements;
2. Collect and report data for state legislative requests;
3. Monitor contractor performance;
4. Evaluate program status and future directions;
5. Provide data for internal monitoring by the contractor.

DEPARTMENT RESPONSIBILITIES--The Department is responsible for:

1. Developing the format for reporting requirements;
2. Reconciling the information on the reports with HCBS summary reports from the Medicaid Management Information System,

## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Reporting Requirements

and information in the contract and request for proposal;

3. Providing technical assistance in the preparation of the reports; and
4. Making available summary information based on the information reported by the contractor or gathered by the Department through the Medicaid Management Information System.

CONTRACTOR RESPONSIBILITIES--The contractor is responsible for:

1. Developing a system to collect data for completing the reports;
2. Ensuring the accuracy of the information reported; and
3. Ensuring that all information reported is documented.

QUARTERLY REPORTS--The quarterly reporting requirements include the following:

- |          |   |
|----------|---|
| Report 1 | No longer required effective April 1, 1996. |
| Report 2 | Provider Prepared Standards                 |
| Report 3 | No longer required as of October 31, 1992.  |
| Report 4 | No longer required effective April 1, 1996. |
| Report 5 | HCBS Utilization Report                     |
| Report 6 | Nursing Facility Transfer                   |
| Report 7 | Waiting List Report                         |

o o o



Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SERVICES

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Contract  
Termination/Transition

CONTRACT REQUIREMENT--The Department is required to give contract agencies written notice of contract termination at least 60 days prior to the effective cancellation date. The Department has the right to full access to the contract agency's facilities and records for the purpose of arranging the orderly transfer of contracted activities.

TRANSITION TO NEW CONTRACTOR--The Department will request certain information to be made available to ensure a smooth transition to a new contractor. The information may include, but will not be limited to the following:

- Names, addresses and phone numbers of recipients served;
- Names, addresses and phone numbers of sub-contract providers;
- Detailed care plans for each recipient;
- Copies of team forms, reports, and any other material developed under the contract.

After the transition to the new contractor, the former contract agency shall be responsible for outstanding claims for services and other financial matters related to the operation of the HCBS program during their contracted period.

o o o



Department of Public Health and Human Services	SECTION:  CASE MANAGEMENT SERVICES
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Transfer of Recipients or Change of Recipient's Classification

GENERAL REQUIREMENT--There are three occasions for transferring cases:

1. A physically disabled recipient in a basic slot turns 65, it is necessary to change the recipient's classification from physically disabled to elderly;
2. A recipient moves from one case management service area to another; and
3. A recipient chooses a different case management team within the same service area.

RECLASSIFICATION--When a physically disabled HCBS recipient turns 65, send a new Entrance/Discharge into Medicaid form (DPHHS-DD/MA-55) to the Eligibility Specialist as notification of the need to change the deprivation code in the recipient's case file. The effective date is the recipient's date of birth. Also send a discharge sheet (DPHHS-MA-137) to the Community Service Bureau and circle #9 (other) and specify that recipient turned 65. The date of discharge should be the day before the recipient's date of birth. Lastly, submit a corrected Intake Sheet (DPHHS-MA-136) to the Community Service Bureau with an explanation of the change. The admit date should be the recipient's date of birth.

TRANSFER PROCEDURES--When a recipient moves from one case management service area to another or selects a different case management provider within the same service area, coordination of services is very important between the transferring and receiving teams. Ideally, the recipient should be able to transfer from one team to another with little or no interruption in the delivery of services.

## SECTION:

CASE MANAGEMENT SERVICES

## SUBJECT:

Transfer of Recipients or  
Change of Recipient's Classi-  
fication

UNINTERRUPTED SERVICE:--If the recipient agrees to transfer the case records to the receiving CMT, there will be a greater opportunity to coordinate services with no or minimal interruption. To allow for uninterrupted transition of services, the receiving CMT can use the recipient's current Plan of Care (POC) for up to 90 days, or until the annual POC is due, whichever date comes first. However, a home visit to discuss current level of services must be done within 30 days of relocation. If the recipient does not agree to transfer the case record, then services by the receiving CMT cannot be instituted until the receiving CMT has completed all steps to enroll the recipient as a new case. This may necessitate a prolonged discharge planning period.

Any amendments or prior authorizations for different or additional services should be done at this time. This will allow the recipient to receive immediate services and maintain the same health care professional until the recipient obtains a local health care professional. At the home visit, the receiving CMT should stress to the recipient that a health care professional must sign off on the new POC when it is due. To facilitate smooth transitions, the following guidelines are suggested for the participating teams.

Transferring  
Case Management  
Team:

1. Make a referral to the receiving case management team or teams (if there is more than one) in the new service area. Ask the receiving CMT about slot availability. If the receiving CMT does not have a slot, the recipient's slot will be transferred to the receiving team until that team has an opening. As soon as the receiving team has a similar slot open (e.g, basic, AR, supported living), the slot will be returned to the transferring CMT. Exchange of slots should be done in writing via memos.

## SECTION:

CASE MANAGEMENT SERVICES

## SUBJECT:

Transfer of Recipients or  
Change of Recipient's Classi-  
fication

2. Discuss transfer choice with the recipient or legal representative. Service coordination can be facilitated easier with the transfer of records. However, if the recipient does NOT want records to be transferred to another team, prepare a discharge sheet and maintain the case record.
3. If the recipient agrees to transfer the records, have the recipient sign a release of information and begin transferring information to the receiving CMT so they can begin to set up new services.
4. Inform the recipient or legal representative to notify the local Office of Public Assistance (OPA) and local Social Security office regarding change of address so that benefits can be forwarded. CMT can assist with these tasks if the recipient is unable.
5. Initiate a modified level of care screen if records are not transferred, to be forwarded to the receiving CMT. If records are to be transferred, send the current level of care, Level 1, Level II, if applicable, and screening determination to the receiving CMT.
6. Help identify the recipient's current needs for the receiving CMT so that they can try to locate providers before the recipient moves. Coordinate with the receiving CMT to ensure a smooth transition.
7. Upon discharge, send discharge sheet (DPHHS-MA-137) to Community Services Bureau and notify providers. If the recipient is moving to another county, send DPHHS-DD/MA-55 to Eligibility Specialist showing effective discharge date. Transfer case records to the receiving team.



## SECTION:

CASE MANAGEMENT SERVICES

## SUBJECT:

Transfer of Recipients or  
Change of Recipient's Classi-  
fication

Receiving  
Case Management  
Team:

1. After obtaining the modified or current level of care screen, make arrangements to discuss service needs with the recipient or legal representative and referring CMT if possible. This can be done via the telephone if travel is a problem, or the transferring CMT can help make arrangements for the recipient to visit the receiving CMT by working with the recipient's family or authorizing supervision and mileage.

When discussing service delivery, the receiving CMT must inform the recipient of all available providers in the area to allow the recipient a choice. If this is done over the telephone, the receiving CMT should send a list of available providers to the recipient and ask the recipient to select providers for each particular service and inform CMT. (Many teams use a freedom of choice checklist form.) The transferring CMT can assist the recipient with this form if necessary.

2. When the recipient has selected the potential providers, CMT can make referrals to those providers.
3. Notify the local Office of Public Assistance and the local Social Security Office regarding incoming transfer of case. Once the recipient moves, follow through to see whether benefits have been transferred. If the recipient has moved from another county, send the Eligibility Specialist a DPHHS-DD/MA-55.
4. Send Intake Sheet (DPHHS-MA-136) to the Community Services Bureau.
5. Document in the Progress Notes a Referral Summary, describing the transferral process.

## SECTION:

CASE MANAGEMENT SERVICES

## SUBJECT:

Transfer of Recipients or  
Change of Recipient's Classi-  
fication

6. If records are transferred within 30 days of the recipient's relocation, the nurse and social worker must make a home visit to assess level of services. Amend the POC if necessary and remind the recipient or legal representative to obtain a local health care professional. If records are not transferred, the CMT must process the application as for a newly enrolled recipient.
7. Within 90 days, or before the annual Plan of Care expires, develop a new Plan of Care for the current services. If case records have been transferred, the social worker can use the former psychosocial summary, but at the time of the new Plan of Care, it should be updated to reflect any changes.

CHANGING CARE CATEGORIES WITH TRANSFER--If the transferring recipient is changing care categories, the referring CMT must request availability of that type of slot. For a recipient in a basic slot who needs supported living services upon transfer, the referring CMT should contact the Community Services Bureau to apply for a supported living slot. For a recipient in a basic slot who needs an Adult Residential Slot upon transfer, the referring CMT should get the recipient's name on the receiving CMT's waiting list if there aren't any openings. For a recipient in a supported living slot who needs a basic slot upon transfer, the recipient can take the supported living slot to the new service area and obtain basic services. This will still be counted as a supported living slot even though the level of services may be the same as a basic slot. As soon as a new basic slot opens (P.D. for those under 65, Elderly for those over 65+), the recipient will take that slot, and the supported living slot will be returned to Helena via a memo.

o o o



Department of Public Health and Human Services  HOME AND COMMUNITY BASED SERVICES	SECTION:  CASE MANAGEMENT SYSTEM
	SUBJECT:  Plan of Care: Development

DEFINITION--A plan of care is a written plan for services developed by the Case Management Team (CMT) and the recipient to assess and determine the latter's status and needs. The plan of care also outlines the services that will be provided to the recipient to meet his identified needs. Refer to Appendix HCBS 899-11 for a copy of the HCBS Plan of Care (DPHHS-MA-135). Each plan of care must be completed following the instructions in 899-11.

REQUIREMENT--An initial plan of care must be developed prior to the person's enrollment. Plans of care must be completed at least annually (refer to HCBS 809-7).

CONSULTATION--The CMT shall consult with the recipient or the recipient's representative and the attending health care professional. The CMT may also consult family members, relatives, psychologists, medical personnel and other consultants as necessary.

DISTRIBUTION--The CMT shall provide a copy of the approved plan of care to the recipient or legal representative.

o o o





Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care: Components

PLAN COMPONENTS--Each individual plan of care (Form DPHHS-MA-135) shall include at least the following components:

1. Diagnosis, symptoms, complaints and complications indicating the need for services;
2. A description of the recipient's functional level;
3. Specific short-term objectives and long-term goals, including discharge potential or plan;
4. Any orders for the following:
  - a. medication;
  - b. treatments;
  - c. restorative and rehabilitative services;
  - d. activities;
  - e. therapies;
  - f. social services;
  - g. diet; and
  - h. other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care.
5. The specific services to be provided, the frequency of services and the type of provider;
6. A psychosocial summary describing the recipient's social, emotional, mental and financial situation attached to the initial plan of care (Refer to Appendix 899-17.); and
7. A cost sheet which projects the annualized costs of HCBS. (Refer to Appendix 899-10).

o o o



Department of Public Health  
and Human Services

**SECTION:**

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Plan of Care: Requirements

REVIEW PROCESS--All Plans of Care are subject to review by the Department. The Department has delegated the review function to the Regional Program Officer (RPO). The RPO is responsible for reviewing all portions of the plan utilizing the criteria outlined below.

REVIEW CRITERIA--Review of the individual Plan of Care will be based on the following:

- Completeness of plan which includes all necessary services being listed in terms of amount, frequency and planned provider(s);
- Consistency of the plan with screening information regarding the recipient needs;
- Presence of appropriate signatures; and
- Cost-effectiveness of plan.

ENROLLMENT DATE--The initial enrollment date is the date the Case Management Team actually begins delivering services (sits down with consumer to develop the plan of care and the recipient signs the plan of care). This date should be entered in the upper left corner of the Plan of Care Form.

NOTIFICATION--The Case Management Team must notify the Eligibility Staff whenever a Medicaid recipient is being admitted in the Home and Community Based Services Program. Notification is made on Form DPHHS-DD/MA-55. (Refer to Appendix 899-6.)

o o o



Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care: Costs

REQUIREMENT--The plan of care must provide documentation of the recipient's plan of care costs. It includes all Home and Community Based Services to be provided, the frequency, amount and projected annualized cost of the services.

PROCEDURE--The Plan of Care Cost Sheet, Form SRS-MA-134, (refer to Appendix 899-10) is prepared by the Case Management Team after the plan of care has been developed. The cost sheet is completed to determine initial program eligibility, when amendments are made to the plan of care, and whenever substantial changes occur in the recipient's service needs or costs at the time of reevaluations. A new cost sheet must also be completed at each annual update of the plan of care.

ANNUAL PLAN OF CARE COST LIMIT--The plan of care cost limit is determined by the Department. Recipients who exceed the plan of care cost limit are not eligible for the Home and Community Based Services Program except as prior authorized by the Department. (Refer to HCBS 410 for prior authorization criteria and procedures).

o o o





Department of Public Health  
and Human Services

**SECTION:**

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Plan of Care: Reevaluations

**REQUIREMENT:**

Plans of care must be formally reevaluated by the Case Management Team (CMT) to review changes in recipient's need for Home and Community Based Services. Formal reevaluations of plans of care or plan of care updates must be completed no later than six months from the initial plan approval. The first annual plan of care update is due 12 months from the initial enrollment date. Refer to Appendix HCBS 899-15 for a copy of the HCBS Reevaluation Form (DPHHS-MA-139) and instructions.

**PROCEDURE:**

During the plan of care reevaluation, the CMT should:

1. See the recipient to assess the current situation;
2. Check with the recipient's attending - health care professional for any new orders;
3. Check with the service provider(s) to review the quality of services being provided;
4. Evaluate the recipient's discharge potential;
5. Document the results of the plan of care reevaluation in the case progress notes; and
6. Attach a plan of care cost sheet (DPHHS-MA-134) to the Amendment Form whenever the projected plan of care costs change as a result of the reevaluation.

## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Plan of Care: Reevaluations

If it appears as if the individual no longer meets level of care, a referral for a LOC screen should be made to the Mountain Pacific Quality Health Foundation for a LOC determination.

## SIGNATURES:

The only signatures required for plan of care reevaluations are the CMT nurse and social worker.

o o o

Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care: Amendments

REQUIREMENT: Amendments to the plan of care are required when unscheduled changes occur in the recipient's situation and either the plan of care or an existing prior authorization needs to be amended.

APPROVAL: Changes to services which cause the plan to be over cost or exceed set limits must have prior approval from the Regional Program Officer (RPO).

PROCEDURE: The results of the plan of care amendments must be documented in case progress notes on the HCBS Amendment Form DPHHS-MA-141. (Refer to HCBS 899-16.) A revised cost sheet should be attached to this form whenever the projected plan of care costs change.

SIGNATURES: The only signatures required for plan of care amendments are the Case Management Team nurse and social worker. Amendments to an existing prior authorization must be approved by the RPO.

o o o





Department of Public Health  
and Human Services

**SECTION:**

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Plan of Care: Annual Updates

**REQUIREMENT:**

A new plan of care and cost sheet must be developed at least every 12 months. The first annual update is due 12 months after the initial enrollment date. Subsequent annual updates are due 12 months from the last annual update.

The Case Management Team (CMT) will make a referral to the Mountain Pacific Quality Health Foundation for a level of care determination before a new plan of care is developed to ensure the recipient still meets level of care.

**PROCEDURE:**

During the plan of care annual update, the CMT must:

1. See the recipient to assess the current situation;
2. Check with the recipient's attending health care professional for any new orders;
3. Check with the service provider(s) to review the quality of services being provided;
4. Evaluate the recipient's discharge potential;
5. Document the results of the annual update in the case progress notes; and
6. Complete a new plan of care cost sheet to cover the projected annual costs for the next annual period covered.

**SIGNATURES:**

The plan of care annual update must contain all signatures required on the initial plan of care. The recipient must sign the new cost sheet.

**SECTION:**

CASE MANAGEMENT SYSTEM

**SUBJECT:**

Plan of Care: Annual Updates

CARE CATEGORY 3  
(CC3) RECIPIENTS:

Copies of the annual plan of care updates and cost sheets for CC3 cases must be forwarded to the Community Services Bureau by the Regional Program Officer for review and approval.

o o o

Department of Public Health  
and Human Services

**SECTION:**

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Discretionary Funds

**Definition:** Discretionary funds are funds given to Case Management Teams (CMT) on a one time basis to meet the needs of recipients. This money is used at the CMT's discretion to meet the needs of current recipients or provide one time or temporary services to individuals in need and waiting for services.

**Requirements:** Discretionary funds are to be used for the following purposes only:

- Environmental Modifications.
- One time purchase of Specialized Medical Equipment & Supplies.
- Temporary increase in existing POC. For example, if a family needed extra respite or supervision time and didn't have funds left in their current POC.
- Temporary services (not to go beyond the end of the fiscal year).

**Procedure:** Individuals Enrolled to Access Discretionary Funds--A Plan of Care Short Form (DPHHS-MA-135B) and Cost Sheet (DPHHS-MA-134) must be completed for individuals enrolled into the HCBS program to access discretionary funds. Instructions for the form are in Section 899-11B.

For recipients enrolled only under the discretionary funds criteria, the hourly case management rate must be used. This rate covers time spent with the recipient, family members, providers, and completing the paperwork. It does not cover travel time to and from the recipient's home.

## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Discretionary Funds

Current Caseload--For recipients already enrolled in the HCBS program, amend the current POC and Cost Sheet. The hourly case management rate does not apply to the current caseload. Use extra lines on page 2 of the cost sheet to indicate services purchased with discretionary funds.

**NOTE OF CAUTION:** All required forms, with the exception of the Psychosocial Summary (DPHHS-MA-143) and the Plan of Care (DPHHS-MA-135) must be completed for individuals accessing discretionary funds. Individuals enrolled must still meet all eligibility criteria (LOC and financial). Do not put individuals on the program just for a Medicaid card. Do not put anyone on the program whom you will not be able to discharge before the end of the fiscal year or incorporate into your current caseload.

o o o



Department of Public Health  
and Human Services

## SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Year-End Money

## Definition:

Year-End Money is distributed to the case management teams toward the end of a fiscal year and is used to meet the needs of current recipients or provide one time or temporary services to individuals waiting for services. Year-End Money is different from Discretionary Funds in Section 810 and is subject to approval from the State Office.

## Requirements:

Year-End Money is used for the following purposes only:

- Environmental Modifications
- One time purchase of Specialized Medical Equipment & Supplies
- Temporary increase in existing POC (for example, if a family needed extra respite or supervision time and didn't have funds left in their current POC.)
- One-time or temporary services to individuals on the waiting list.

## Procedure:

Individuals Enrolled Only to Access Year-End Money--A Plan of Care Short Form (DPHHS-MA-135B) and cost sheet must be completed for individuals enrolled into the HCBS program to access Year-End Money. Instructions for the form are in Section 899-11B. For clients enrolled only under the Year-End Money criteria, the hourly case management rate must be used. This rate covers time spent with the recipient, family members, providers, and completing the paperwork. It does not cover travel time to and from the recipient's home. Case managers should keep a log tracking their time and add it up upon submission of a claim.



## SECTION:

CASE MANAGEMENT SYSTEM

## SUBJECT:

Year-End Money

Individuals Currently on HCBS Caseload-- For recipients already enrolled in the program, amend the current POC and cost sheet. Use the empty lines on page 2 of the cost sheet for services provided with Year-End Money. The hourly case management rate does not apply to this group of individuals.

Overcost Plans of Care--The State Office and the Regional Program Officers will already have approved the Year-End Expenditures. Therefore, prior-authorizations for overcost plans of care resulting from Year-End expenditures will not be required.

## Billing:

HCFA 1500--All HCFA 1500s must have a date-of-service within the fiscal year during which the Year-End Money was distributed. This should be the date a service was provided, the date an item was ordered, or the date an agreement was signed to provide services such as environmental modifications. When billing for Year-End Money you and your providers must use the existing HCBS procedure codes with the modifier "WM" attached to them. An environmental modification purchased with Year-End Money would be billed as Z0515WM. When submitting prior authorizations to Consultec for Year-End Money services, CMTs must also use the HCBS procedure codes with the "WM" modifier.

**NOTE OF CAUTION:** Individuals enrolled must still meet all eligibility criteria (LOC and financial). Do not put individuals on the program just for a Medicaid card. Do not put anyone on the program for temporary services whom you will not be able to discharge before the end of the fiscal year or incorporate into your current caseload by the end of the fiscal year. All required forms, except the Psychosocial Summary (DPHHS-MA-143) and Plan of Care (DPHHS-MA-135, long version) must be completed.

o o o

Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Consumer Advisory Council

Each case management team must have attached to it a consumer advisory council. The council must be representative of the CMT's caseload and advise the team on the provision of HCBS services, long term care services, and general issues impacting them and their community. Each council may be unique and reflect the needs of the recipients served by that particular team.

PURPOSE: The purpose of the council is to ensure consumer input in the HCBS Program and to provide consumers a more active voice in the direction of long term care services in their communities.

REQUIREMENT: Council members are to be individuals who were previously, or are currently, on the case management team's caseload; or a family member of an individual on the current caseload.

PROCESS: The advisory council must develop by-laws including a mission statement, an explanation of its role vis-a-vis the program and frequency of meetings, and nominate officers. The council must keep minutes of each meeting and submit them to the HCBS Program Manager. For the council's consideration, we have included optional guidelines and recommendations to be used at the council's discretion. Refer to HCBS 812-1.

o o o



## CONSUMER ADVISORY COUNCILS GUIDELINES AND RECOMMENDATIONS

### PURPOSE

The purposes of the HCBS local advisory councils are: 1) to provide consumers a more active voice in the direction of long-term care services in their communities; 2) to provide ongoing support and advice to local case management teams; 3) to advocate for and encourage other HCBS consumers; and 4) to help develop programs or services to meet the continuing challenges faced by Montana's seniors and individuals with long-term physical disabilities.

### OBJECTIVES

Advisory councils will convene at least quarterly to discuss decisions affecting services through HCBS. This core group of consumers will present its concerns and suggestions to the local case management teams. Regional Program Officers, representing the Department, will act as liaisons between the advisory councils and the case management teams to insure that the consumers' choices are honored when permissible within program parameters.

Local advisory councils can advise case management teams on such matters as referrals, waiting lists, year-end expenditures, approving medically necessary adaptive equipment, improving quality of care, public education and overall program development. Major recommendations will be presented to the Department, which will consider the legal ramifications and financial feasibility.

### CONFIDENTIALITY

It is not anticipated that these councils will deal with confidential matters. However, if confidential matters arise in the course of these meetings, council members are bound by the confidentiality standards under law and Department policy.

### MEMBERSHIP

Each council should consist of a minimum of five members and a maximum of 13. Excluding those case management teams that serve only one population, councils should comprise a balance between senior and younger consumers for equal representation. Members should plan to participate for three-year terms. Staggered terms are recommended so that there will always be both new and experienced members. For example, for the first year select a minimum of five members. Their terms would expire in three years. The following year, add two more members, whose terms would then expire in three years.

Councils should consist predominately of current HCBS consumers, but former HCBS consumers and family members or significant others can also serve. It is also recommended that councils include at least one interested professional and one non-professional member in the community as advisory members. HCBS Consumers will choose these latter two individuals as representatives. (Department personnel and HCBS case managers are excluded from active council membership.)



## MEETINGS

Case Management Teams will provide or arrange for a handicap-accessible meeting space for these councils at least quarterly.

Each meeting should have an agenda including new and old business. Topics for the agenda can come from the case management team, the advisory group, other HCBS consumers or family members, or the Department. For efficacy of these meetings, basic parliamentary procedures are recommended to conduct business. A brief format of these rules is included and will be provided to the councils for guidance.

It is recommended that upon convening for the first time, the consumers choose co-chairs to facilitate meetings and to appoint at least one person to take minutes.

For HCBS consumers, social mileage and personal assistance socialization under HCBS will be allowed for participation in these meetings.

## FIVE BASIC PRINCIPLES OF PARLIAMENTARY PROCEDURE

1. Only one person may speak to the group at one time.
2. Each proposal presented to the council is entitled to full and open debate.
3. Every member has rights equal to every other member.
4. The majority rules, but the rights of the minority must be preserved.
5. The desires of each member should be incorporated into the larger whole.

## THE CHAIR

The chair assumes leadership of the meeting to keep it flowing smoothly, calls the meeting to order, acknowledges only one member at a time, requests motions, follows the agenda, adheres to basic parliamentary procedures, and calls for the meeting adjournment.

### Opening the Meeting

The chair asks for a motion to accept or revise the minutes of the last meeting. Once the minutes have been approved, the chair follows the outline of the agenda.

### Making Motions

1. Obtain the floor by being recognized by the chair.
2. State the motion.
3. Get motion seconded.
4. The chair should repeat the motion, getting clarification, or adjusting the wording, if necessary.
5. The motion is then open for discussion.
6. After adequate discussion, the chair restates the motion and asks for a vote.



### Amending Motions

1. To add words.
2. To delete word.
3. Substitute specific words.
4. Substitute another motion.

The amendment is then discussed and seconded. Amendments may only be amended once.

### Adjourning Meetings

1. Chair asks for a motion to adjourn.
2. After motion is seconded and voted upon, the chair announces next meeting time and place.



Department of Public Health  
and Human Services

SECTION:

CASE MANAGEMENT SYSTEM

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

SECTION RESERVED FOR FUTURE USE

o o o



Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Reporting Requirements, Forms  
& Instructions

REPORT 1: This report is discontinued effective April 1, 1996.

REPORT 2: PROVIDER PREPARED STANDARDS--This report summarizes the results of the Case Management Team's internal audit of case records. A sample chart audit must be conducted at least quarterly with the findings summarized on this table. No less than a ten percent random sample is recommended for the audit. The organization and composition of the audit team is left to the discretion of the contractor. All standards reviewed should have supporting documentation in the individual case record. Only Medicaid cases should be reported on this summary.

NUMBER OF RECORDS REVIEWED--Enter the total number of records reviewed during the reporting quarter.

REVIEW DATE(S)--Enter the actual review date(s) or the review quarter when records were reviewed.

NAMES OF RECORDS REVIEWED--Enter recipient names for the records reviewed.

STANDARD REVIEWED--This column lists the specific standards being reviewed in the chart audit.

INITIAL CONTACT--This standard indicates whether initial contact with the individual requesting services was made within three working days of receipt of the referral.

MEDICAID ELIGIBILITY--This standard indicates whether proof of Medicaid eligibility exists in the case record. The best source of documentation is a copy of the Medicaid identification card. Other forms of documentation or verification will be accepted.



## SECTION:

## APPENDIX

## SUBJECT:

Reporting Requirements, Forms  
& Instructions

RESIDENCY--This standard indicates whether the individual resides in an approved service area and an approved setting. Services cannot be provided to recipients who are inpatients of a hospital, nursing facility or ICF-MR.

HCBS COSTS--This standard indicates whether HCBS costs exceeded the plan of care limit. The Department must prior authorize all exceptions to the plan of care limit.

PLAN OF CARE COMPLETENESS--This standard indicates whether records included an approved written plan of care that met the recipient's needs and addressed the following components:

1. Recipient identifying information;
2. Medical information;
3. Functional overview;
4. Orders for medication, treatments or other services recommended to meet plan of care objectives;
5. Specific services to be provided, the frequency of services and the types of providers permitted to render such services;
6. Suitable goals and objectives;
7. Psychosocial summary as attachment to plan of care;
8. Clear and concise discharge plan;
9. Cost sheet with projected annualized costs of each service; and
10. All required dated signatures.

## SECTION:

## APPENDIX

## SUBJECT:

Reporting Requirements, Forms  
& Instructions

PLAN OF CARE REEVALUATIONS--This standard indicates whether plans of care were reevaluated no later than six months from initial plan approval and at intervals of at least six months thereafter.

ANNUAL PLAN OF CARE UPDATES--This standard indicates whether a new plan of care and cost sheet was completed.

CONTENT OF RECIPIENT RECORDS--This standard indicates whether recipient charts contained all of the following:

1. Referral forms;
2. Mountain Pacific Quality Health Foundation preadmission screen;
3. Level I Screen or PASARR
3. Initial screening results (DPHHS-MA-61);
4. Plans of care;
5. Cost sheets;
6. Readable progress notes that detail involvement in developing/reviewing plans of care, monitoring quality of care, review of necessity of services, etc.;
7. Reevaluation/amendment forms; and
8. Prior authorization forms.

AUTHORIZATION OF SERVICES--This standard indicates whether prior authorizations for HCBS services were submitted by the Case Management Team and were only for services approved in the recipient's plan of care.

## SECTION:

APPENDIX

## SUBJECT:

Reporting Requirements, Forms  
& Instructions

CASE CLOSURE (NOTIFICATION)--This standard indicates whether discharge sheets were completed and appropriate individuals were notified when the case was closed.

FINDINGS--Enter the number of records found to be correct, incorrect or not applicable for each standard.

DATE AND TYPE OF ACTION--Enter the date and type of specific corrective action to be taken for those cases found to be incorrect.

MANUAL--The HCBS Manual must be accessible and up-to-date.

STAFFING--Case Management Teams must include registered nurse(s) and social worker(s) who meet the qualifications outlined in the approved contract. In addition the team must have support staff sufficient to meet the demands of the workload.

DISTRIBUTION--Case Management Teams should maintain these reports. The reports will be reviewed during compliance reviews by the Regional Program Officers.

REPORT 3: This report is discontinued effective October 31, 1992.

REPORT 4: This report is discontinued effective April 1, 1996.

REPORT 5: HCBS UTILIZATION REPORT--This is a quarterly report submitted to the Department 30 days after the end of each quarter indicating utilization of all Home and Community Based Services. The report is broken down into categories of service (basic, adult residential, supported living, residential habilitation heavy care, TBI and year-end money).



## SECTION:

APPENDIX

## SUBJECT:

Reporting Requirements, Forms  
& Instructions

This report will be used by the Department to track HCBS expenditures and to ensure that Case Management Team's total plan of care costs are within their allocated budget amount.

Procedure: Case Management Team--Enter name of case management team.

Contact Person--Enter name of person to contact to answer questions regarding the report.

Quarter Ending--Enter the last day of the quarter to which the report applies.

<u>QUARTER ENDS</u>	<u>DUE TO DEPARTMENT</u>
9/30	10/31
12/31	1/31
3/31	4/30
6/30	7/31

Date Submitted--Enter the date the report is submitted to the Department.

Number of Recipients Served--Enter the number of recipients served for each category of service.

Total Cost Per Category-- Enter the total cost for each category of service.

Total Basic/Adult Residential--Enter the total number of recipients served and costs of basic and adult residential.

Total for Quarter--Enter the total number of recipients served and costs of all categories of service.

Year-End Money--Enter the name of recipient, procedure code and amount of each year-end money request completed in the quarter.

SECTION:

APPENDIX

SUBJECT:

Reporting Requirements, Forms  
& Instructions

REPORT 6: NURSING FACILITY TRANSFER--This is a quarterly report submitted to the Department 30 days after the end of each quarter listing new admits to Home and Community Based Services who have transferred from a nursing facility.

Procedure: Case Management Team--Enter name of case management team.

Quarter Ending--Enter the last day of the quarter to which the report applies.

<u>QUARTER ENDS</u>	<u>DUE TO DEPARTMENT</u>
9/30	10/31
12/31	1/31
3/31	4/30
6/30	7/31

Prepared By--Enter name of person to contact to answer questions regarding the report.

Recipient Name & Address--Enter the recipient's name and address.

Social Security Number--Enter recipient's social security number.

Name of Nursing Facility & City--Enter name of the nursing facility and city.

Nursing Facility Discharge Date--Enter the date recipient is discharge from the nursing facility.

HCBS Admit Date--Enter the date the recipient is admitted to Home and Community Based Services.

REPORT 7: WAITING LIST REPORT--This is a quarterly report submitted to the Department 10 days after the end of each quarter indicating the number of individuals waiting for HCBS program slots.

Procedure: Use provided database software. (Refer to 899-25.)

o o o



(Rev. 1/99)  
Page 1 of 2

Page 7 of 10

# HOME AND COMMUNITY BASED SERVICES PROVIDER PREPARED STANDARDS

(Rev. 1/99)  
Page 2 of 2

STANDARD REVIEWED	FINDINGS			DATE & TYPE OF ACTION
	CORRECT	INCORRECT	N/A	
5. Plan of Care Completeness				
Recipient Identifying Information				
Medical Information				
Functional Overview				
Orders for Medication, etc.				
Specific Services				
Goals and Objectives				
Psychosocial Summary				
Discharge Plan				
Cost Sheet				
Signatures				
6. Plan of Care Reevaluations				
7. Annual Plan of Care Updates				
8. Content of Recipient Records				
9. Authorization of Services				
10. Case Closure (Notification)				
11. Findings				
12. Date and Type of Action				
13. Manual				
14. Staff				

(Rev. 7/00)

# HOME AND COMMUNITY BASED SERVICES QUARTERLY UTILIZATION REPORT

Case Management Team \_\_\_\_\_

Contact Person \_\_\_\_\_

Quarter Ending \_\_\_\_\_ Date Submitted \_\_\_\_\_

Category of Service	Number of Recipients Served	Total Cost Per Category
Basic (Elderly/Physically Disabled)		
Adult Residential		
Total Basic/Adult Residential		
Supported Living		
Residential Habilitation		
Ventilator Dependent		
TBI-Bridges/Headway		
Total for Quarter		

## Year-End Money

Name of Recipient	Procedure Code	Amount
Total for Quarter		

HOME AND COMMUNITY BASED SERVICES  
NURSING FACILITY TRANSFER REPORT

Case Management Team:			
Quarter Ending:		Prepared By:	
Recipient Name & Address	Social Security Number	Name of Nursing Facility & City	Nursing Facility Discharge Date
			HCBS Admit Date

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Case Management Performance  
Standards

1. Recipient charts must be complete and compiled in accordance with section HCBS 310.
2. The number of case management staff including support staff must be sufficient to serve the Medicaid caseload size.
3. Selection of individuals from the waiting list must follow process indicated in 413.
4. Individuals on waiting list must have had a documented in-person visit by the team within 60 days of the initial referral.
5. Individuals on waiting list who no longer require HCBS program must be removed from waiting list.

o o o





Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Home and Community Based  
Services Forms Requisition

PURPOSE: This form is used to order home and community based services forms from the Department.

INSTRUCTIONS: The provider agency fills in the quantity of forms needed for a six month period and sends the forms requisition to the address listed on the form.

Case management teams may copy page 2 to order forms.

All forms come in bundles of 50 except the MA-142 and MA-147. Please do not put down number of bundles, use total number of forms. For example: 100 not 2. Forms can be requested in smaller quantities.

o o o

**SENIOR & LONG TERM CARE DIVISION****HOME & COMMUNITY BASED SERVICES  
FORMS REQUISITION**

Send to: Ann McKenzie  
 Senior & LTC Division  
 P.O. Box 4210  
 Helena, MT 59604-4210  
 Phone: 406-444-4077  
 Fax: 406-444-7743

Location Code: **650**

Requesting Office Name:

Request Date:

Street  
Address:

City:  
Zip Code:

Telephone No:

Signature of Requestor:

Date Shipped:

Quantity Requested	Quantity Sent	Form Number	Form Name
_____	_____	DD/MA-55 . . . . .	Entrance Into Medicaid & HCBS (Rev. 4/96)
_____	_____	MA-63 . . . . .	Request for Modified Screen (Rev. 8/96)
_____	_____	MA-86 . . . . .	Level of Care Determination (Rev. 5/96)
_____	_____	MA-132 . . . . .	HCBS Adult Residential Care Calculation (Rev. 1/99)
_____	_____	MA-134 . . . . .	HCBS Plan of Care Cost Sheet - Page 1 (Rev. 4/97)
_____	_____	MA-134 . . . . .	HCBS Plan of Care Cost Sheet - Page 2 (Rev. 4/97)
_____	_____	MA-135 . . . . .	HCBS Plan of Care - Page 1 (Rev. 4/99)
_____	_____	MA-135 . . . . .	HCBS Plan of Care - Page 2 (Rev. 4/99)
_____	_____	MA-135 . . . . .	HCBS Plan of Care - Page 3 (Rev. 9/99)
_____	_____	MA-135 . . . . .	HCBS Plan of Care - Page 4 (Rev. 9/95)
_____	_____	MA-135B . . . . .	HCBS Plan of Care Short Form (New 12/97)
_____	_____	MA-136 . . . . .	HCBS Intake Sheet (Rev. 1/97)
_____	_____	MA-137 . . . . .	HCBS Discharge Sheet (Rev. 1/97)
_____	_____	MA-138 . . . . .	PAS HCBS Referral/Amendment Form (Rev. 9/98)
_____	_____	MA-139 . . . . .	HCBS Reevaluation Form (Rev. 9/95)
_____	_____	MA-141 . . . . .	HCBS Amendment Form (New 8/97)
_____	_____	MA-142 . . . . .	HCBS Service Animals-Provider Assurances (New 7/98)
_____	_____	MA-143 . . . . .	HCBS Psychosocial Summary (New 7/95)
_____	_____	MA-144 . . . . .	HCBS Letter of Notification (Rev. 11/95)
_____	_____	MA-145 . . . . .	Level I Screen (Rev. 5/96)
_____	_____	MA-146 . . . . .	HCBS Waiting List Criteria Tool (Rev. 9/95)
_____	_____	MA-147 . . . . .	HCBS Service Animals-Stewardship Agreement (New 7/98)
_____	_____	MA-148 . . . . .	HCBS Request for Prior Authorization CC3 (New 2/96)
_____	_____	MA-149 . . . . .	HCBS Request for Prior Authorization (Rev. 1/99)

**NOTE:**

All forms come in bundles of 50 except the MA-142 and MA-147. Please do not put down number of bundles, use total number of forms. For example: 100 not 2. Forms can be requested in smaller quantities. If you do not receive the forms you ordered, please call the above number.

Department of Health and  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care Cost Limits

PLAN OF CARE COST LIMITS--

FY 84	\$11,600
FY 85	\$12,753
FY 86	\$13,074
July 1986 - December 1986	\$14,126
January 1987 - June 1987	\$13,946
FY 88	\$14,281
FY 89	\$18,425
FY 90	\$19,852
FY 91	\$20,455
FY 92	\$17,363
FY 94	\$17,363
FY 95	\$17,363
FY 96	\$20,000
FY 00	\$21,000
FY01	\$22,000

o o o





Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Entrance Into Medicaid & HCBS  
(DPHHS-MA-55) Instructions

PURPOSE: This form is originated by the Case Management Team (CMT) to enroll a recipient into Home and Community Based Services (HCBS) or discharge a recipient from HCBS.

DISTRIBUTION: CMT retains pink copy as a suspense copy. White and yellow copies are sent to the county where Medicaid eligibility is determined. The county office will complete its portion of the form and retain the yellow copy for its files. The white copy will be returned to the CMT.

INSTRUCTIONS: Applicant--Enter identifying information of the recipient.

Referring Case Management Team--Enter name, agency, date referral sent to county, address and phone number of CMT making referral.

Enrollment Request--Enter name of county office where financial eligibility is determined.

Effective Date--Enter the date HCBS is scheduled to start. The effective date should be the same date as the admit date on the Intake Sheet (DPHHS-MA-136).

HCBS Waiver--Indicate appropriate waiver category.

Discharge Request--Enter the date HCBS is terminated. The discharge date should be the same date as the discharge date on the Discharge Sheet (DPHHS-MA-137).

To Be Completed By County Office--The county office will complete this portion of the form and return a copy to the CMT.

o o o

## ENTRANCE/DISCHARGE INTO MEDICAID HOME AND COMMUNITY BASED SERVICES

### APPLICANT:

Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_  
Placement Address: \_\_\_\_\_

### REFERRING CASE MANAGEMENT TEAM:

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Date to County: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### ENROLLMENT REQUEST:

Notification to Eligibility Specialist: \_\_\_\_\_ County office: \_\_\_\_\_

This is to notify you that the above-named individual has been enrolled in the Medicaid Home and Community Based Services (HCBS) Waiver Program. Please ensure that this recipient is listed in TEAMS by the Medicaid subtype listed below when Medicaid eligibility has been established. Income and resource deeming requirements are waived when the applicant/recipient is otherwise eligible for an HCBS waiver.

**Effective Date when HCBS is scheduled to start:** \_\_\_\_\_

HCBS coverage dates must be entered on the Waiver Client Information (WACI) screen in TEAMS.

#### HCBS Waiver:

- ☐ WA -- Aged Waiver  
☐ WD -- Physically Disabled Waiver  
☐ WO -- Developmentally Disabled/Other Waiver - For WO only - DDD staff: If formerly in Nursing Facility or ICF/MR, please note where and discharge date.

\_\_\_\_\_  
Facility

\_\_\_\_\_  
Discharge Date

DDD Authorization for WO \_\_\_\_\_

### DISCHARGE REQUEST:

**Effective Date when HCBS is terminated:** \_\_\_\_\_

HCBS coverage dates must be entered on the Waiver Client Information (WACI) screen in TEAMS.

### TO BE COMPLETED BY COUNTY OFFICE:

Notification to Referral Originator:

- ☐ Individual approved for Medicaid effective \_\_\_\_\_.  
**WACI Screen span has been entered.**

- ☐ Individual denied Medicaid on \_\_\_\_\_ date.

- ☐ No record of Medicaid application

- ☐ Incurment (spend down)/Amount \_\_\_\_\_

☐ Cash Option

☐ Using Case Management Team fees for Aged and Physically Disabled (WA & WD)

☐ Other (explain) \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Eligibility Specialist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department of Public Health  
and Human Services

**SECTION:**

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Request for Modified Screen/  
MA-61 Issuance (DPHHS-MA-63)  
Instructions

- PURPOSE:** To request an updated level of care authorization for long term care services for an HCBS recipient or applicant who has had a previous level of care screen completed which is no longer valid.
- PROCEDURE:** CMT completes this form when it is necessary prior to admitting a new recipient to HCBS or when discharging an HCBS recipient to a nursing facility. The most common reasons for needing an updated level of care screen are listed in the second box on the form.
- DISTRIBUTION:** CMT retains the yellow copy and forwards the original copy to the Mountain Pacific Quality Health Foundation.
- INSTRUCTIONS:** Identifying Information--Complete recipient identifying information.
- Reason Requesting Screen--Check the reason for requesting an updated level of care screen.
1. Document date of referral to HCBS or nursing facility (NF) admit date.
  2. Document date of previous Level of Care Determination.
  3. Verify continuous stay in NF or HCBS. If a person had been previously discharged and then readmitted at a later date, the stay is not continuous. Document only the current stay.
  4. Document Medicaid eligibility status.
  5. Document medical diagnoses, any changes in functional capabilities, and the continued need for long term care services.

**SECTION:**

APPENDIX

**SUBJECT:**Request for Modified Screen/  
MA-61 Issuance (DPHHS-MA-63)  
Instructions

6. Give name and phone number of person completing form and date of completion.

PASARR--Document date of original Level I and Level II, if one was required.

FOR FOUNDATION USE ONLY--The Foundation will complete this section.

o o o



## REQUEST FOR MODIFIED SCREEN/MA-61 ISSUANCE

Recipient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date: \_\_\_\_\_

If current nursing facility resident, nursing facility name: \_\_\_\_\_ City: \_\_\_\_\_

**Reason requesting screen:**

- ☐ Determination over 60 days old (wasn't admitted to nursing facility, in nursing facility but denied financially-reapplying, or was or placed on HCBS waiting list)
- ☐ Nursing facility to Home and Community Based Services
- ☐ Home and Community Based Services to nursing facility
- ☐ Extension of temporary authorization
- ☐ Other: \_\_\_\_\_

1. Referral to Home and Community Based Services (HCBS) or nursing facility admit date: \_\_\_\_\_

2. Date of previous Level of Care Determination: \_\_\_\_\_

3. Verify continuous stay:

Dates of services in nursing facility: \_\_\_\_\_

Dates of services in HCBS program: \_\_\_\_\_

Anticipated length of stay: \_\_\_\_\_

4. Medicaid Eligibility (indicate date where applicable):

Open (y/n) \_\_\_\_\_ Applying (y/n) \_\_\_\_\_

5. Current status:

Medical diagnoses: \_\_\_\_\_

\_\_\_\_\_

Changes in functional capabilities: No \_\_\_\_\_ Yes \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Document continued need for Long-Term Care Services: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Information source:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

PASARR: Date of Level I: \_\_\_\_\_ Date of Level II: \_\_\_\_\_

### FOR FOUNDATION USE ONLY

Status Verification Order: \_\_\_\_\_

Meets NF LOC \_\_\_\_\_ Does not meet NF LOC \_\_\_\_\_ Effective Date: \_\_\_\_\_

Screener: \_\_\_\_\_ Date: \_\_\_\_\_





Department of Public Health  
and Human Services

**SECTION:**

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Level of Care Determination  
(DPHHS-MA-86) Instructions

**PURPOSE:** This form is used by the Mountain Pacific Quality Health Foundation to record information in order to make a level of care determination for nursing facility placement or the Home and Community Based Services (HCBS) program.

**PROCEDURE:** Nursing facilities, and other interested agencies or individuals may fill out the form to the best of their knowledge and mail or fax the form to the Foundation. The Case Management Teams will fill out the form for the yearly reevaluation.

**INSTRUCTIONS:**

**PAGE 1:** Program Requested--Check the name of the program being requested:

Nursing Facility or HCBS. HCBS includes HCBS in the community, adult residential care, and residential hospice. Mark "Unknown" if a decision has not been made as to which program the applicant may choose.

Identifying Information--Enter legal name of applicant, Social Security Number, mailing address, telephone number, date of birth, age, sex, Medicaid status and veteran status of the applicant.

Nursing Facility Admit Date--Enter the **actual** date the applicant entered the nursing facility. You may indicate a projected date to enter the nursing facility but note that this is a projected date.

Medicare Skilled--Check if the applicant was Medicare skilled and the date skilled services were initiated.

**SECTION:**

APPENDIX

**SUBJECT:**

Level of Care Determination  
(DPHHS-MA-86) Instructions

Previous Medicaid Screen and Date--Check if a prior Medicaid screen was completed and give the date of the screen.

Date of Request--Enter the date the requestor is mailing or faxing the request for the level of care determination.

Anticipated LOS--Enter the anticipated length of stay in months, weeks etc. If it is anticipated to be a long term stay please indicate so.

Screen Requested By--Enter the name of the person who is requesting the screen.

Agency--Enter the name and phone number of the agency requesting the screening determination.

Applicant Location--Enter the location of the applicant at the time of the screening.

Significant Other--Enter the name of the significant other, whether it be a relative, neighbor, etc. who is a contact person or who knows significant information about the applicant.

Relationship and Phone--Enter the relationship and phone number of the significant other. List the work number if appropriate.

Address--Enter the mailing address of the significant other including street address or box number, city, state and zip code.

Other Contacts--List the name and phone number of other contacts the Foundation may call.

Health Care Professional--Enter the name and phone number of the applicant's health care professional and state the type of professional (M.D., nurse practitioner or physician assistant).

## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

Medical Diagnosis/Summary--List the diagnosis of the applicant and other pertinent medical information.

Special Treatments/Medications/Therapies--List any special treatments, therapies and medications the applicant is receiving.

Social and Other Information--List any information the referral source feels would be helpful or significant in making the level of care determination.

Dementia--Check the "yes" box if the applicant has a diagnosis of dementia. Check the "no" box if this does not pertain to this applicant.

Traumatic Brain Injury (TBI)--Check the "yes" box if the applicant has a diagnosis of TBI. Check the "no" box if the applicant does not have a diagnosis of TBI.

Communication Deficit--Check the "yes" box if the applicant has a problem with communication. Indicate if the applicant's primary language is another language other than English. Check the "no" box if the applicant is able to hear and talk over the phone, etc.

FOR FOUNDATION USE ONLY--This section is to be completed by the Foundation only.

Compliance Review--Department staff will complete this section when conducting a compliance review.

cc--The Foundation will mark who will receive a copy of this screening determination.

PAGE 2:

## FUNCTIONAL ASSESSMENT

The requestor of the level of care screen should complete as much of the form as they have information.

Each area should be rated with respect to the person's age-appropriate capabilities, using



## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

the following coding system and explanation of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

*0=Independent:* The applicant is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting, or supervision.

*1=With Aides/Difficulty:* To fulfill the ADL/IADL, the applicant requires consistent availability of mechanical assistance or the expenditure of undue effort.

*2=With Help:* The applicant requires consistent human assistance, in the absence of which the ADL cannot be completed. The applicant does, however, actively participate in the completion of the activity.

*3=Unable:* The applicant cannot meaningfully contribute to the completion of the task.

**NARRATIVE/ASSESSMENT CATEGORIES**

*Current Status/Services--*Should describe any identified problems/inadequacies and should reflect current human or mechanical assistance the applicant receives to perform that task.  
*Adequate:* Should reflect whether the assistance (or lack of) is sufficient to meet the applicant's needs.

*Comments:* Should reflect any potential risks to the loss of service provision and any alternative service resources the applicant may access or be eligible for to accommodate the identified deficit.

**ACTIVITIES OF DAILY LIVING**

Bathing--Determine whether the applicant's ability to access bath needs (shower, bathtub, or bed bath) to maintain adequate hygiene as needed for his/her circumstances. Consider minimum hygiene standards, medical prescrip-



## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

tion, or health related considerations such as skin ulcers, lesions, or balance problems.

Mobility--Identify the applicant's capability to navigate his/her internal and external environment, to include: ability to maneuver around the house; ability to negotiate entrances and exits to the home; and ability to access essential places outside of the home.

Toileting--Assess the applicant's capacity to manage bowel and bladder functions. A recipient who has a catheter or stress incontinence but is able to manage self care associated with that condition should be rated "1" and termed "adequate" in comments.

Transfers--Assess the applicant's ability to maneuver between positions such as into and out of bed, chair, toilet (including bed pan), etc. Include the ability to reach assistive devices and appliances necessary to ambulate and the ability to transfer between bed and wheelchair, walker, etc.; the ability to adjust the bed or place/remove handrails (if applicable). Do not rate ambulation abilities, as this is measured under mobility.

Eating/Feeding--Assess the applicant's ability to feed self, cut food into manageable pieces, chew, swallow food/beverages, and pour liquids. This does not refer to meal preparation.

Grooming--Assess the applicant's grooming skills, including: shaving, combing hair, washing face and brushing teeth. If assistance is required (mechanical or human), identify the frequency and nature of assistance required.

Medication--Assess the applicant's ability to manage his/her medication regimen, to include: name, purpose, medication frequency, and ability to manipulate containers and/or equipment.

## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

Dressing--Assess the applicant's ability to dress and undress self, including: fastening, and removing clothing, shoes, braces, and artificial limbs.

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

Shopping--Address the applicant's ability to shop for groceries and other essential items, assuming transportation or delivery is available. Assessment items include selection of items, carrying purchases, communicating needs, etc. Do not measure transportation or money management.

Cooking--Determine whether the applicant is able and follows through with preparation of regular, nutritionally balanced meals. If the applicant is on a prescribed diet, assess whether s/he is following the diet as prescribed. Assess whether the applicant can prepare light meals, reheat meals, and whether s/he is aware of the need to eat a wide variety of foods and selects accordingly.

Housework--Assess the applicant's ability to perform routine housekeeping activities. Assess the applicant's ability, physically and cognitively, rather than his/her actual performance. Consider minimum hygienic conditions required for the applicant's health and safety.

Laundry--Assess the applicant's ability to sort, carry, load and unload, fold, and put away clothing. Consider cognitive and physical abilities to complete this task.

Money Management--Assess the applicant's ability to pay bills, exchange currency, budget, etc. If the applicant is functionally illiterate, consider the level of assistance needed to perform these functions.

Telephone--Assess the applicant's ability to locate telephone numbers, place calls, reach

## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

and use telephone, and articulate and comprehend calls.

Transportation--Assess both the applicant's ability to use transportation (ability to enter/exit vehicles, ability to identify destination, etc.) and the availability of transportation.

Socialization/Leisure Activities--Assess the availability of daily social contacts/ supports; the applicant's participation in groups, clubs, or religious activities; the applicant's interest/participation in structured leisure activities or hobbies, and; the applicant's level of social support or social isolation.

Home Environment--Assess areas of safety (to include need for structural repairs, fire safety, presence/absence of pest infestation, adequate windows, heating resources), security (adequate locks, safety of neighborhood), and satisfaction (location, cost, accessibility of social support systems) of home environment. Include an assessment of the appropriateness of the environment, in terms of its fit with the applicant and his/her need for adaptive equipment or other resources to maintain residence in that environment.

Ability to Summon Emergency Help--Assess the applicant's abilities, cognitively and physically, to recognize an emergency situation and to summon appropriate assistance if necessary.

Deficiencies/problems identified through the functional assessment should be weighted to determine those of such severity that imminent harm (injury, illness, or other health consequences) may result from inability to accomplish the identified activity. Applicants for whom ratings indicate the need for mechanical or human assistance should be further assessed



## SECTION:

APPENDIX

## SUBJECT:

Level of Care Determination  
(DPHHS-MA-86) Instructions

to determine the availability of such resources. "Comments" should include identification of supplemental needs and/or resources to improve the adequacy of the assessed area.

Patient Mental Status--This section provides cues to indicate any cognitive or emotional factors which may impact the applicant's current functional capacity. Check all issues which apply to the applicant's mental status.

FOUNDATION USE ONLY--The Foundation will complete this section documenting if the current service is adequate and any comments.

Patient Mental Status--This section documents any cognitive or emotional factors which may impact the applicant's current functional capacity. Check all issues which apply to the applicant's mental status.

Oriented-- Check box

Coding for Functional Capabilities--This section refers to physiological factors which might impact the applicant's current functional capabilities. Coding for Functional Capabilities should be interpreted as follows:

0=Good: Within normal limits

1=Impaired: Some loss of functioning, however loss is correctable and/or loss does not prevent the applicants capacity to meet his/her needs.

2=Total Loss: No reasonable functional capacity.

List any assistive devices used by applicant.

o o o

## LEVEL OF CARE DETERMINATION

Program Requested: ☐ Nursing Facility ☐ HCBS (Initial) ☐ HCBS Reevaluation ☐ Unknown

### Identifying Information

Applicant: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Medicaid Status: \_\_\_\_\_  
Veteran: ☐ Yes ☐ No  
County of Application: \_\_\_\_\_  
Nursing Facility Admit Date: \_\_\_\_\_  
Medicare Skilled ? \_\_\_\_\_ Date \_\_\_\_\_  
Previous Medicaid Screen ? \_\_\_\_\_ Date \_\_\_\_\_

Date of Request: \_\_\_\_\_  
Anticipated LOS: \_\_\_\_\_  
Screen Request By: \_\_\_\_\_  
Agency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Applicant Location: \_\_\_\_\_  
Significant Other: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Other Contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Summary/Diagnoses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Treatments/Medications/Therapies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social and Other Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dementia: ☐ Yes ☐ No Traumatic Brain Injury: ☐ Yes ☐ No Communication Deficit: ☐ Yes ☐ No

### For Foundation Use Only

Review Start Date: \_\_\_\_\_  
NF Level of Care: ☐ Yes ☐ No Level I Date: \_\_\_\_\_  
Care Category ☐ NF ☐ NF/Rehab ☐ Hospital  
Temporary Stay: \_\_\_\_\_ to \_\_\_\_\_  
RPO Technical Assist: ☐ RPO Onsite: ☐  
Precipitating Placement Factor: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Criteria Met: \_\_\_\_\_

HCBS Referral: ☐ Yes ☐ No Date: \_\_\_\_\_  
CMT: \_\_\_\_\_  
NF Placement: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Screener: \_\_\_\_\_ Complete Date: \_\_\_\_\_  
Foundation Contacts: Name and Phone Number  
1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

Compliance Review ☐ Yes ☐ No By: \_\_\_\_\_ Date: \_\_\_\_\_

cc: Case Management Team \_\_\_\_\_; Nursing Facility \_\_\_\_\_; Referral Source \_\_\_\_\_



## RATING SCALE DEFINITIONS:

Follow this scale when completing the Functional Assessment Portion of the Screen.

- 0 = Independent: The individual is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting or supervision.
- 1 = With Aids/Difficulty: To fulfill ADL/IADL, the individual requires consistent availability of mechanical assistance or the expenditure of undue effort.
- 2 = With Help: The individual requires consistent human assistance, prompting or supervision, in the absence of which the ADL/IADL cannot be completed. The individual does however actively participate in the completion of the activity.
- 3 = Unable: The individual cannot meaningfully contribute to the completion of the task.

Follow this scale when completing the Functional Capabilities Portion of the Screen.

- 0 = Good: Within normal limits.
- 1 = Impaired: Some loss of functioning, however loss is correctable and/or loss does not prevent the individual's capacity to meet his/her needs.
- 2 = Total Loss: No reasonable residual capacity.

# FUNCTIONAL ASSESSMENT

Name \_\_\_\_\_

HCBS 899-8

Coding for Functional Assessment: 0 - Independent 1 - With Aids/Difficulty 2 - With Help 3 - Unable

## FOUNDATION USE ONLY

ADLS	Current Status/Service	Adequate	Comments
Bathing		Yes No	
Mobility		Yes No	
Toileting/ Continence		Yes No	
Transfers		Yes No	
Eating		Yes No	
Grooming		Yes No	
Medication		Yes No	
Dressing		Yes No	
IADL	Current Status/Service	Adequate	Comments
Shopping		Yes No	
Cooking		Yes No	
Housework		Yes No	
Laundry		Yes No	
Money Management		Yes No	
Telephone		Yes No	
Transportation		Yes No	
Socialization/ Leisure Activities		Yes No	
Home Environment		Yes No	
Ability to Summon Emergency Help		Yes No	

Patient Mental Status: (check all appropriate responses) Oriented: Person ☐ Place ☐ Time ☐

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Occasionally disoriented | <input type="checkbox"/> Inappropriate Behavior | <input type="checkbox"/> Medication Abuse      | <input type="checkbox"/> Sleep Problems   |
| <input type="checkbox"/> Disoriented              | <input type="checkbox"/> Confused               | <input type="checkbox"/> Alcohol/Drug Abuse    | <input type="checkbox"/> Worried/Anxious  |
| <input type="checkbox"/> Unresponsive             | <input type="checkbox"/> Long Term Memory Loss  | <input type="checkbox"/> Isolation             | <input type="checkbox"/> Loss of Interest |
| <input type="checkbox"/> Impaired Judgment        | <input type="checkbox"/> Short Term Memory Loss | <input type="checkbox"/> Danger to Self/Others |   |

Coding for Functional Capabilities: 0 - Good 1 - Impaired 2 - Total Loss List Assistive Device:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Vision _____           | <input type="checkbox"/> Hearing _____            | Respiratory Status _____  |
| <input type="checkbox"/> Speech _____           | <input type="checkbox"/> Ambulation _____         | 24-Hour Supervision Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Bowel Continence _____ | <input type="checkbox"/> Bladder Continence _____ |   |

Comments: \_\_\_\_\_



Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Adult Residential Care  
Calculation (DPHHS-MA-132)  
Instructions

**PURPOSE:** This form is used by the Case Management Team (CMT) to calculate the daily rate for Adult Residential Care.

**DISTRIBUTION:** The CMT completes the form with the recipient and provider to determine the rate. The provider must sign the form acknowledging they approve the rate and keeps the pink copy. The CMT sends the yellow copy to the Community Services Bureau.

**INSTRUCTIONS:** Recipient Name--Enter the name of the recipient.

Medicaid Number--Enter the recipient's Medicaid number.

Facility Name--List the name of the adult residential care facility.

PCF, AFH--Check the type of facility being used:

PCF - Personal Care Facility  
AFH - Adult Foster Home

A Bed, B Bed--Check the type of bed being used.

(A) Room & Board--Enter the correct amount the recipient pays to the facility. This will always equal the current SSI amount minus \$100.00. The SSI amount will change every January 1 due to a cost of living (COLA) increase. If the recipient does not receive the full SSI amount, the recipient must pay the difference.

(B) Service Package--\$600 is the basic service amount established by DPHHS.

(C) Support Services--Those services provided by the facility. Assess the recipient's needs and rate the impairment level in conjunction with the supports the facility will provide. For example, a



## SECTION:

## APPENDIX

## SUBJECT:

Adult Residential Care Calculation  
(DPHHS-MA-132) Instructions

recipient may be totally dependent in medication management; but if the facility only provides minimal assistance in medication management, the recipient should receive a score of 1 in that category.

0 = Independent: No impairment. The individual is able to complete the activity without difficulty and has no need for assistance. Need is met with adaptive equipment or service animal. If the need is met or the facility does not provide the service, enter 0. The facility must actually provide the service listed below.

1 = Minimal Supervision--Mild impairment. The individual is able to complete the activity, but requires standby assist, cuing, prompting, or set up help.

2 = Direct Assist--Moderate impairment. The individual is able to moderately participate in the activity, but requires assistance to complete the task.

3 = Extensive Assist--Severe impairment. The individual is able to minimally participate in the activity, but requires extensive assistance to complete the task.

4 = Total Dependence--Total impairment. The individual is not able to participate in the activity and requires total assistance for the task to be completed.

Bathing = Assistance with sponge, bed, tub or shower bathing, with or without assistive devices.

Personal Hygiene = Assistance with routine hair care, oral care, shaving, washing hands and face.

Dressing = Assistance selecting, putting on, and taking off clothes, adaptive, prosthetic or assistive devices.



## SECTION:

## APPENDIX

## SUBJECT:

Adult Residential Care Calculation  
(DPHHS-MA-132) Instructions

Toileting = Assistance getting to the bathroom, managing clothing, diapers, catheter, colostomy bag, or cleaning self.

Medication Management = Assistance with reminders, opening containers, obtaining refills, supplies and equipment.

Medical Management = Assistance with scheduling and/or accompanying to medical appointments, obtaining medical information from health care professional, monitoring compliance.

Transfers = Assistance getting in and out of bed, chair, vehicle. Assistance in positioning themselves in bed, chair or vehicle. (This does not include tub and toilet, which are scored in bathing and toileting support services).

Mobility = Assistance with ambulation inside, outside, on uneven surfaces with or without assistive devices.

Diet = Assistance with preparation or following a medically prescribed diet.

Eating = Assistance with feeding self, pour liquids, cut, chew, swallow with or without assistive devices. (Note: J or G tube feedings only if nurse delegated)

Exercise = Assistance with routine medically prescribed exercise.

Housekeeping = Assistance with laundry, bedding that needs to be changed more than 1 time a week, room cleaning that needs to be done more than 1 time a week.

Socialization = Assistance with one on one socialization, assistance to and from activities (this does not include ambulation assist which is scored in the ambulation support service).

## SECTION:

## APPENDIX

## SUBJECT:

Adult Residential Care Calculation  
(DPHHS-MA-132) Instructions

Communication = Assistance with speech, hearing, visual, or language with or without assistive devices.

Behavior Management = Assistance with wandering, combativeness, or other inappropriate actions.

Impaired Judgment = Assistance with decision-making.

Memory Cueing = Assistance with cognitive deficits, frequency of reminders of daily living activities with or without assistive devices. (Example; assisting individual with making and using a memory book.)

Time Management = Assistance with scheduling/reminding of non-medical activities. (This differs from socialization in that the individual requires help in managing their time.)

Money Management = Assistance with budgeting and/or paying bills.

Transportation = Assistance with accessing non-medical transportation.

Other = Assistance with other support services not described above.

**REMINDER:** The residential care provider is responsible for the following in the service package and no points may be assigned on the rate calculation form for these basic services:

Food: Nutritious menu planning, shopping for food, preparation and serving of 3 meals and 2 snacks a day, set up and clean up of the meal and snacks.

Homemaking: One time a week general room cleaning, laundering bedding 1 time a week and general upkeep of the building.

## SECTION:

## APPENDIX

## SUBJECT:

Adult Residential Care Calculation  
(DPHHS-MA-132) Instructions

Medication Oversight: Medication stored in a separate, safe and secure area and oversight (to the extent permitted under state Law).

Social and Recreation: Common areas made available and opportunities for socialization and recreation time daily.

Supervision: 24-hour on-site response staff to meet scheduled or unpredictable needs and to provide supervision of safety and security.

Medical Transportation: Arrange for medical transportation as needed.

Calculate the support services score by adding up the total score.

Multiply the score by \$33 and write the product in the box.

(D) (A+B+C)--List the total by adding the following:

- (A) Room & Board
- (B) Service Package
- (C) Support Services Total

(E) Enter the facility's private pay rate.

(F) Total to facility is the lesser of D or E but no more than the maximum Medicaid payment.

(A) Room & Board--Enter the amount from section (A).

(A1) State Supplement--List the state supplement amount if applicable. (See note on page 6.)

PCF = \$94.00

AFH = \$52.75

A recipient in a "B" bed does not qualify for state supplement. If the recipient is not eligible for state supplement, enter 0.



## SECTION:

APPENDIX

## SUBJECT:

Adult Residential Care Calculation  
(DPHHS-MA-132) Instructions

(A2) Enter amount of incurment amount used for adult residential service if applicable.

(G) Sub-Total--Add the room & board to the state supplement or the incurment amount if applicable, to determine the recipient's responsibility.

(H) Medicaid responsibility (F-G)--Subtract (the amount of the recipient's responsibility) from F (the lesser of the two rates) to determine H (the amount of Medicaid's responsibility).

Divide the Medicaid responsibility by 30 days to determine the Medicaid daily rate.

Effective Date--Enter the date for which this rate is effective.

Provider Signature--Provider must sign and date the form.

CMT Signature--Case manager must sign and date the form.

## NOTE:

Following are some scenarios that may occur with state supplement payments:

The CMT has just been notified the recipient has been receiving state supplement but it is not included in the SLTC-132. Recalculate the SLTC-132 including the state supplement amount and make the effective date the first day of the following month. **DO NOT** make the date retroactive.

A recipient has been residing in a facility for some time and the SLTC-132 does not include the state supplement amount. The CMT realizes the recipient qualifies for state supplement. The CMT recalculates a new SLTC-132 including the state supplement and makes the effective date the first day of the following month. **DO NOT** make the date retroactive.

o o o

**HOME AND COMMUNITY BASED SERVICES  
ADULT RESIDENTIAL CARE CALCULATION**

Recipient Name: \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Facility Name: \_\_\_\_\_ PCF \_\_\_\_\_ AFH \_\_\_\_\_ A Bed \_\_\_\_\_ B Bed \_\_\_\_\_

(A) Room & Board 

The amount for R&amp;B is set by DPHHS, but collected from the recipient by facility.

(B) Service Package 

The basic service amount established by DPHHS.

(C) Support Services

Support service rate is based upon individual needs and established by the case management team for DPHHS. If the need is met or the facility does not provide the service, enter 0. The facility must actually provide the service listed below.

	LOC Score		LOC Score
Bathing	<input type="text"/>	Housekeeping	<input type="text"/>
Personal Hygiene	<input type="text"/>	Money Management	<input type="text"/>
Dressing	<input type="text"/>	Socialization	<input type="text"/>
Toileting	<input type="text"/>	Transportation	<input type="text"/>
Medication Management	<input type="text"/>	Communication	<input type="text"/>
Medical Management	<input type="text"/>	Behavior Management	<input type="text"/>
Mobility	<input type="text"/>	Impaired Judgment	<input type="text"/>
Transfers	<input type="text"/>	Memory Cueing	<input type="text"/>
Eating	<input type="text"/>	Time Management	<input type="text"/>
Diet	<input type="text"/>	Other _____	<input type="text"/>
Exercise	<input type="text"/>	Other _____	<input type="text"/>

**SCORING KEY**

0 = Independent - Includes assist from family or others or need is met.

1 = Minimal Assist - Set up help, prompting.

2 = Direct Assist - With active participation of individual to complete task.

3 = Extensive Assist - With limited participation of individual to complete task.

4 = Total Dependence - With no participation of individual to complete activity.

Total LOC Score  x \$33.00 (D) (A+B+C) (E) Facility Private Pay Rate (F) Total to facility is the less of D or E 

The following outlines the responsibility of payment to the facility:

Recipient Responsibility:

(A) Room & Board (A1) State Supplement (A2) Incurment used for AR services (G) Sub-Total 

Effective Date \_\_\_\_\_

(Not to exceed the Medicaid maximum daily rate)

(H) Medicaid Responsibility (F-G) Divided by 30 days 

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

CMT Signature \_\_\_\_\_ Date \_\_\_\_\_



## Directions for Completing Calculation Sheet

**To figure total cost (recipient's share + Medicaid payment):**

- |     |   |                 |
|-----|---|-----------------|
| (A) | Enter room and board  | SSI minus \$100 |
| (B) | Enter basic service package amount  | \$600           |
| (C) | Calculate support service score by assessing recipient needs. Multiply score by \$33  | xxx             |
| (D) | Total to Facility (A+B+C)<br>(Only if this total is less than the provider's usual charge; use provider's charge if it is the lesser amount.) | xxxx            |

**Recipient responsibility:**

- |      |   |                 |
|------|---|-----------------|
| (A)  | Room and board  | SSI minus \$100 |
| (A1) | State Supplement - if applicable<br>(Only recipients who receive straight SSI AND are in an A bed are eligible for state supplement. If recipient is not eligible for State Supplement, enter 0.<br>PCF = \$94.00 AFH = \$52.75 | xxx             |
| (A2) | If individual is using any portion of Incurment for AR services, enter that amount. If not, enter 0.  | xxx             |
| (F)  | Total recipient responsibility  | xxxx            |

**Medicaid responsibility:**

**Total to facility (F) minus recipient responsibility (G) = Medicaid responsibility (H)**  
**Divide (H) by 30 to get Medicaid daily rate.**

**NOTE:** The Medically Needy incurment for Adult Residential Care (ARC) applicants will be determined in the same way as it is for any HCBS recipient. Medically Needy recipients may choose to meet their monthly incurment obligation using the "cash option" or the "medical expense option."

Recipients choosing the "incurred medical expense option" will not be eligible for any services until the expenses have been incurred and the bills/receipts are presented to the eligibility worker (i.e., the recipient's daily ARC rate (G in calculation above) must be furnished to the eligibility worker). For example, if the recipient's monthly incurment obligation is \$300 and his daily rate is \$30, the client will not be eligible for Medicaid covered services until after he has incurred \$300 in medical expenses (\$30 x 10 days = \$300).

Recipients should be encouraged to choose the "cash option" because eligibility for Adult Residential Care, as well as all other Medicaid covered services, will begin the first day of the month.

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care Cost Sheet  
(DPHHS-MA-134) Instructions

**PURPOSE:** The cost sheet is used to project the cost of the plan of care during the care plan year. The Case Management Team (CMT) completes the cost sheet after the care plan has been developed. A new cost sheet is required for any subsequent amendments to the care plan which change the cost of the plan.

**DISTRIBUTION:** The CMT retains the white copy and sends the yellow copy to the recipient.

**INSTRUCTIONS:**

**PAGE 1:** Recipient Name -- Enter the name of the recipient.

Annual Period Covered--Enter the span of the care plan year (month and year).

Unit Cost--Enter the unit cost of the service.

Weekly Number of Units--Enter the number of units to be used each week.

Quarterly Number of Units--Enter the number of units to be used in the quarter.

Projected Quarterly Costs--Enter the projected cost of the service in the quarters it will be used.

Projected Annual Costs--Enter the projected annual cost for each service to be used during the care plan year.

Recipient's Signature--The recipient must sign the cost sheet.

## SECTION:

APPENDIX

## SUBJECT:

Plan of Care Cost Sheet  
(DPHHS-MA-134) Instructions

Date--Have recipient enter the date the cost sheet is signed.

Institutional Comparison Code--Enter the maximum plan of care cost, 20,000 for CC1 and CC2 recipients. Do not place the dollar sign (\$) in front of the number.

Subtotal Page 1--Enter the total of the projected annual cost for page 1.

PAGE 2

Complete page 2 if Habilitation or TBI services are used.

Subtotal Page 2--Enter the total of the projected annual cost for page 2.

Total Plan of Care Cost--Enter the total cost of the plan adding subtotals from pages 1 and 2.

o o o



## HOME AND COMMUNITY BASED SERVICES - PLAN OF CARE COST SHEET

Annual Period Covered:

Recipient Name:

HCBS SERVICE	UNIT COST	WEEKLY # OF UNITS	QTRLY # OF UNITS	PROJECTED QUARTERLY COSTS				PROJECTED ANNUAL COST
				QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	
Adult Residential Care <input type="checkbox"/> Foster Home <input type="checkbox"/> Personal Care Facility (Z0549) <input type="checkbox"/> Residential Hospice								
Adult Day Health (Z0506)								
Case Management (Z0519)								
Chemical Dependency Counseling- <input type="checkbox"/> Individual (Z0548) <input type="checkbox"/> Group (Z0551)								
Dietitian (Z0524)								
Environmental Accessibility Adaptations (Z0515)		XXXXXX	XXXXXX					
Homemaker (Z0501)								
Homemaker Chore (Z0553)								
Nutrition (meals) (Z00518)								
Occupational Therapy (Z0531)								
Personal Assistance Service - Attendant (Z0573)								
Personal Assistance Service - Nurse Supervision (Z0574)								
Personal Emergency Response System - Purchase (Z0516)		XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	
Personal Emergency Response System - Rental (Z0517)								
Physical Therapy (Z0529)								
Private Duty Nursing (Z0526)								
Psychosocial Consultation (Z0527)								
Respiratory Therapy (Z0525)								
Respite Care - Facility (Z0511)								
Respite Care - Hour (Z0512)								
Registered Nurse Supervision (Z0528)								
Special Child Care for Children with AIDS (Z0550)								
Specialized Medical Equipment & Supplies (Z0552)								
Specialty Trained Attendants (Attendant Care) (Z0545)								
Speech Therapy (Z0530)								
Transportation - Trip (Z0513)								
Transportation - Miles (Z0514)								

Recipient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Institutional Comparison Code \_\_\_\_\_

Subtotal Page 1 \_\_\_\_\_

Subtotal Page 2 \_\_\_\_\_

Total Plan of Care Cost \_\_\_\_\_

# HOME AND COMMUNITY BASED SERVICES - PLAN OF CARE COST SHEET

**Recipient Name:**

Annual Period Covered:

[illegible]

**Recipient's Signature**

Date \_\_\_\_\_

Subtotal Page 2



Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

**PURPOSE:** To provide an assessment of a recipient's physical and social needs for Home and Community Based Services (HCBS) and to develop a care plan, with the recipient, to meet the recipient's needs. The Case Management Team (CMT) completes Form DPHHS-MA-135 upon initial assessment and for annual update of the recipient's need for HCBS.

The plan of care is an agreement between the recipient and the Case Management Team for the provision of HCBS. A discussion of the recipient's discharge potential must take place during the initial assessment and at the annual review.

**DISTRIBUTION:** The CMT retains the suspense (pink) copy in its files while obtaining appropriate signatures on the original and yellow copies. Once these signatures are obtained, the CMT retains the white copy and sends the yellow copy to the recipient.

**INSTRUCTIONS:**

**PAGE 1:** Admit Date--Enter the date of initial admittance.

Update--Enter the date of HCBS reevaluation.

Level I Date-- Enter the date the Level I was approved by Mountain-Pacific Quality Health Foundation. (Reminder: This date must be the same or before the admission date.)

Foundation Reevaluation Date--Enter the date the level of care reevaluation was completed by the Mountain-Pacific Quality Health Foundation.

Level II--Check "No" if a Level II was not required. Check "Yes" if a Level II was completed. Check "MR" for a Mental Retardation evaluation and

## SECTION:

APPENDIX

## SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

"MI" for a Mental Illness evaluation. If both evaluations were completed, check both boxes.

Level II Date--Enter date(s) of completed evaluation(s). (Reminder: These date(s) must be the same or before to the admission date.)

Care Category--Enter appropriate level of care. Care Category 3 (CC3) plans require prior authorization.

Discharges/Readmits--Enter dates of discharge and readmits.

Recipient--Enter the recipient's name, address and telephone number.

Medicaid Number (SSN)--Enter the recipient's Medicaid identification number.

Date of Birth--Enter the recipient's date of birth.

Height--Enter the recipient's height.

Weight--Enter the recipient's weight.

Sex--Enter M for Male or F for female.

Marital Status--Enter the recipient's marital status. (Single, married, divorced, widowed, or separated.)

Responsible Party--Enter the name, address and telephone number of the person responsible for the recipient. This could be a spouse, relative, legal guardian, etc. Indicate the relationship to the recipient.

Significant Other--Enter the name, relationship to recipient, address and telephone number of recipient's significant other.

Attending Health Care Professional--Enter the name, address and telephone number of the recipient's

## SECTION:

APPENDIX

## SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

attending health care professional. The health care professional may be a M.D, nurse practitioner or physician assistant.

Hospital Preference--Enter the hospital the recipient prefers to use.

Eligibility Category--Enter elderly or disabled and if recipient is under 21.

Residential Status--Enter the recipient's residential status under HCBS. If none of the three choices applies, write in the residential status.

Medicare--Enter "Yes" if Medicare eligible and Medicare number. Enter "No" if not Medicare eligible.

Other Insurance--Enter name, address, and phone number of any other insurance.

Veteran--Enter "Yes" if eligible for veteran benefits. Enter "No" if not.

Date of Referral--Enter the date recipient was referred for services. This is completed only on initial assessments.

Referral Source--Enter the name and telephone number of the individual or agency who referred the recipient. This is completed only on initial assessments.

Interview Date--Enter the date the recipient was interviewed. This is completed only on initial assessment.

Allergies--Enter any known allergies of the recipient.

Medical Diagnoses--Enter all current and pertinent medical diagnoses and the date(s) of diagnoses, if possible. Enter the primary diagnosis first.



## SECTION:

APPENDIX

## SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

ICD-9 Code--Enter the ICD-9 code for the diagnosis(es) of the recipient.

Medications--Enter all current medications prescribed, dosages and frequency.

Comments--Enter any other pertinent comments relating to the recipient's overall medical condition.

PAGE 2:

Recipient Name--Enter recipient name and date.

Mental Status/Psychosocial Status--Briefly describe the recipient's mental and psychosocial status (lucid, alert, confused, combative). Enter any problems with orientation, judgment, memory, energy, motivation, sleep patterns, behavior, delusions, depression, grief, isolation, fear, low self-esteem, agitation, sexuality, etc.

Diet--Enter any special diet requirements such as diabetic, low salt, etc.

Safety Measures--Enter pertinent instructions regarding safety or precautionary measures required or used; e.g., side rails at all times.

Assistive Devices Used--List any appliances/prosthetic devices/assistive technology that the recipient uses such as walker, wheelchair, dentures, glasses, braces, etc.

Crisis Intervention Plan--Describe how crises or emergencies will be handled.

Functional Overview--Enter for each task whether the recipient is independent, needs assistance or is dependent. Indicate whether the tasks are done by someone other than the recipient; e.g., spouse. Compare these to the assessments on the Level of Care Determination form (DPHHS-MA-86). If there is a significant difference, contact your RPO or the Foundation.

## SECTION:

APPENDIX

## SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

Other Treatment/Therapies/Social Services and Informal Support Systems--Enter all other treatments, therapies or services provided to the recipient. Enter the problem, need, provider and frequency of service. This section would include all services to the recipient that are not paid for through HCBS; e.g., State Plan Medicaid services, meals-on-wheels, adult protective services, home health, volunteer services, etc.

PAGE 3: Recipient Name--Enter recipient name and date.

Service Delivery Plan--Enter for each HCBS service the identified support required, the type and/or name of the service provider and frequency of service. Service provider and frequency must be specific. For example, provider name--2 hours per day, 3 times a week (Monday, Wednesday, Friday).

PAGE 4: Recipient Name--Enter recipient name and date.

Plan Assessment Summary--Summarize the recipient's plan of care, including short-term objectives and long-term goals. Be specific in stating goals and objectives. Attach additional pages if required. RN should complete the physical summary and SW should complete social summary.

Discharge Plan--The CMT must address the recipient's discharge potential and plan from Home and Community Based Services.

Signatures--Signatures of all individuals who participated in development of the plan of care. All signatures must be dated.

This includes dated signatures of the following:

- Recipient - The recipient must sign the plan unless unable to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the care plan should contain a note explaining that the recipient was unable to sign. No one should sign the



## SECTION:

APPENDIX

## SUBJECT:

Plan of Care (DPHHS-MA-135)  
Instructions

recipient's name on their behalf. If the recipient has a legal representative, the representative must sign.

- Health Care Professional - A health care professional (HCP) may be a physician, physician assistant certified, or a nurse practitioner. In rare instances, the plan can be approved without the HCP's signature, but only if an explanation is attached. This might occur in such cases where the HCP is not available, a telephone approval has been made or the HCP has written a letter indicating a recommendation for home and community services. These are considered presumptive approvals. The HCP signature must be obtained within 30 days of the effective date of the plan or the services must be discontinued.
- Case Management Team Nurse and Social Worker - Both members of the Case Management Team must sign the care plan. The plan may be initially approved with only one signature if one team member is not available, but the other member must review, sign and date the plan upon their return.

o o o

Admit Date: _____		Update: _____		DISCHARGES		READMITS																																																									
Level I Date: _____																																																															
Level II: No _____ Yes _____ MR <input type="checkbox"/> MI <input type="checkbox"/> Level II Date: _____																																																															
Care Category: Nursing Facility (CC1/CC2) _____ Hospital (CC3) _____																																																															
Recipient Name (Last, First, Middle)			Address			Phone																																																									
Medicaid Number (SSN)			Date of Birth	Height	Weight	Sex	Marital Status																																																								
Responsible Party (Name/Relationship)			Address			Phone																																																									
Significant Other (Name/Relationship)			Address			Phone																																																									
Primary Health Care Professional			Address			Phone																																																									
Hospital Preference			Eligibility Category: ( ) Elderly ( ) Disabled ( ) Under 21		Residential Status: ( ) Lives Alone ( ) Other ( ) Lives with Family ( ) Live-in Attendant																																																										
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare #		Other Insurance				Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No																																																									
Date of Referral to HCBS		Referral Source		Phone Number		Interview Date																																																									
Date of Referral to PAS		Referral Source		Phone Number		Intake Date																																																									
Allergies																																																															
<table border="1"><thead><tr><th>DATE</th><th>MEDICAL DIAGNOSES</th><th>ICD-9 CODE</th><th>DATE</th><th>MEDICAL DIAGNOSES</th><th>ICD-9 CODE</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>								DATE	MEDICAL DIAGNOSES	ICD-9 CODE	DATE	MEDICAL DIAGNOSES	ICD-9 CODE																																																		
DATE	MEDICAL DIAGNOSES	ICD-9 CODE	DATE	MEDICAL DIAGNOSES	ICD-9 CODE																																																										
<table border="1"><thead><tr><th>DATE</th><th>MEDICATIONS</th><th>DOSAGE</th><th>FREQUENCY</th><th>DATE</th><th>MEDICATIONS</th><th>DOSAGE</th><th>FREQUENCY</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>								DATE	MEDICATIONS	DOSAGE	FREQUENCY	DATE	MEDICATIONS	DOSAGE	FREQUENCY																																																
DATE	MEDICATIONS	DOSAGE	FREQUENCY	DATE	MEDICATIONS	DOSAGE	FREQUENCY																																																								
Comments: _____																																																															

Mental Status/Psychosocial Status

Diet: ( ) General ( ) Diabetic ( ) Low Salt ( ) Other (Specify)

Safety Measures/Functional Limitations (Specify)

Assistive Devices Used

Crisis Intervention Plan

**FUNCTIONAL OVERVIEW**

TASK	INDEPENDENT	NEEDS ASSISTANCE	DEPENDENT	TASK	INDEPENDENT	NEEDS ASSISTANCE	DEPENDENT
Bathing				Laundry			
Dressing				Shopping			
Exercise				Socialization			
Grooming				Telephone			
Toileting				Vision			
Continence				Hearing			
Transfer				Speech			
Mobility				Banking			
Assistive Devices				Money Mgmt			
Meal Preparation				Orientation			
Eating				Transportation			
Medications				Time Mgmt			
Escort				Other			
Household				Other			

**OTHER TREATMENT/THERAPIES/SOCIAL SERVICES AND INFORMAL SUPPORT SYSTEMS**

SERVICE	PROBLEM/NEED	PROVIDER	FREQUENCY



Recipient Name \_\_\_\_\_

Date \_\_\_\_\_

**SERVICE DELIVERY PLAN**

SERVICE	SUPPORT REQUIRED	PROVIDER	FREQUENCY
Adult Day Health			
Adult Residential Care <input type="checkbox"/> Adult Foster Home <input type="checkbox"/> Personal Care Facility			
Behavioral Programming			
Case Management			
Chemical Dependency Counseling			
Cognitive Rehabilitation			
Community Residential Rehabilitation			
Comprehensive Day Treatment			
Specialized Child Care for Children with AIDS			
Dietitian			
Environmental Accessibility Adaptations			
Habilitation <input type="checkbox"/> Day Habilitation <input type="checkbox"/> Habilitation Aide <input type="checkbox"/> Residential Habilitation			
Prevocational Services <input type="checkbox"/> Recipient ineligible for Voc Rehab			
Supported Employment <input type="checkbox"/> Recipient ineligible for Voc Rehab			
Homemaker			
Nutrition/Meals			
Occupational Therapy			
Personal Emergency Response System			
Personal Assistance Service			
Physical Therapy			
Private Duty Nursing			
Psychological Consultation			
Respiratory Therapy			
Residential Hospice			
Respite Care			
RN Supervision			
Specialized Medical Equipment and Supplies			
Specially Trained Attendants			
Speech Therapy			
Supported Living			
Transportation			

**PLAN ASSESSMENT SUMMARY****PHYSICAL SUMMARY:**

Long-Term Goals:

Short-Term Objectives:

**PSYCHOSOCIAL SUMMARY:**

Long-Term Goals:

Short-Term Objectives:

**DISCHARGE PLAN**I have a free choice of all qualified providers of HCBS for each service included in my Plan of Care. ☐I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program. ☐I have participated in the development of this Plan of Care and agree with it. ☐

Recipient: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)
 Legal Representative: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

Significant Other: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)
 CMT Nurse: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

Health Care Professional: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)
 CMT Social Worker: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)



Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Plan of Care Short Form  
(DPHHS-MA-135B) Instructions

PURPOSE:

To provide a brief assessment of a recipient's need for Home and Community Based Services (HCBS) and to develop a care plan, with the recipient, to meet the recipient's short term and/or one time only needs, or residential hospice. The Case Management Team (CMT) completes Form DPHHS-MA-135B upon initial assessment for individuals enrolled with year-end money or lump-sum discretionary funds, for placement in a residential hospice, or short term temporary enrollment.

This plan of care is an agreement between the recipient and the CMT for the provision of short term and/or one time only HCBS services. A discharge plan must be discussed with the recipient and documented on this form.

DISTRIBUTION:

The CMT retains the suspense (pink) copy in its files while obtaining appropriate signatures on the original and yellow copies. Once these signatures are obtained, the CMT retains the white copy and sends the yellow copy to the recipient.

INSTRUCTIONS:

Admission Date--Enter the date of initial admit.

Level I--Enter the date the Level I was approved by Mountain Pacific Quality Health Foundation. (Reminder: This date must be the same as or before the admission date.)

Level II--Check "No" if a Level II was not required. Check "Yes" if a Level II was completed. Mark "MR" for a Mental Retardation evaluation and "MI" for a Mental Illness evaluation. If both evaluations were completed, mark both boxes.

## SECTION:

APPENDIX

## SUBJECT:

Plan of Care Short Form  
(DPHHS-MA-135B) Instructions

Date--Enter date(s) of completed evaluation(s). (Reminder: These date(s) must be the same as or before the admission date.)

Recipient--Enter the recipient's name, address and telephone number.

Medicaid Number (SSN)--Enter the recipient's Medicaid identification number.

Date of Birth--Enter the recipient's date of birth.

Height--Enter the recipient's height.

Weight--Enter the recipient's weight.

Sex--Enter M for male or F for female.

Marital Status--Enter the recipient's marital status. (Single, married, divorced, widowed, or separated.)

Responsible Party--Enter the name, address and telephone number of the person responsible for the recipient. This could be self, a spouse, relative, legal guardian, etc. Indicate the relationship to the recipient.

Attending Health Care Professional--Enter the name, address and telephone number of the recipient's attending health care professional. The health care professional may be a M.D, nurse practitioner or physician assistant.

Residential Status--Enter the recipient's residential status (private residence, with a spouse or relative, nursing facility, hospital, group residence, licensed personal care facility, adult foster home, or other--please specify).

## SECTION:

## APPENDIX

## SUBJECT:

Plan of Care Short Form  
(DPHHS-MA-135B) Instructions

Eligibility Category--Enter elderly or disabled.

Care Category--Enter appropriate level of care. Care Category 3 (CC3) plans require prior authorization.

Veteran--Enter "Yes" if eligible for veteran benefits. Enter "No" if not.

Date of Referral--Enter the date recipient was referred for services. This is completed only on initial assessments.

Referral Source--Enter the name and telephone number of the individual or agency who referred the recipient. This is completed only on initial assessments.

Interview Date--Enter the date the recipient was interviewed. This is completed only on initial assessment.

Brief Description of Need for Service -- Summary statement describing primary reasons individual needs HCBS.

Medical Summary: Medications and Allergies/ Diagnosis/ICD9 Code--Enter any known allergies of the recipient. Enter the primary diagnosis and other diagnoses and medications pertinent to the HCBS service to be provided and the ICD9 Code for each.

Service Plan--List the home and community based services to be provided, the type of service provider and frequency.

Discharge Date--The CMT must indicate a specific discharge date.

Signatures--Signatures of all individuals who participated in development of the plan of care. All signatures must be dated.



## SECTION:

APPENDIX

## SUBJECT:

Plan of Care Short Form  
(DPHHS-MA-135B) Instructions

This includes dated signatures of the following:

1. Recipient - The recipient must sign the plan unless unable to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the care plan should contain a note explaining that the recipient was unable to sign. No one should sign the recipient's name on his behalf. If the recipient has a legal representative, the representative must sign.
2. Health Care Professional - The health care professional may be a M.D, nurse practitioner or physician assistant.
3. Case Management Staff--Only one member of the Case Management Team is required to develop the MA-135B. This member must sign and date this care plan.

o o o

## HOME AND COMMUNITY BASED SERVICES PLAN OF CARE SHORT FORM

Admission Date: \_\_\_\_\_  
(Date)

Annual Update: \_\_\_\_\_  
(Date)

Level I: \_\_\_\_\_  
(Date)

Level II: No \_\_\_\_\_ Yes \_\_\_\_\_ MR ☐ MI ☐  
Date: \_\_\_\_\_

Recipient Name (Last, First, Middle)		Address			Phone
Medicaid Number (SSN)	Date of Birth	Height	Weight	Sex	Marital Status
Responsible Party (Name/Relationship)		Address			Phone
Attending Health Care Professional		Address			Phone
Residential Status		Eligibility Category:		Care Category:	
Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No		( ) Elderly ( ) Disabled		( ) Nursing Facility ( CC1/CC2) ( ) Hospital ( CC3)	
Date of Referral	Referral Source		Phone Number		Interview Date

Brief Description of Need for Services

Medical Summary/Allergies/Diagnosis/ICD9 Code

Service Plan

Discharge Date:

I have a free choice of all qualified providers of HCBS for each service included in my Plan of Care. ☐  
I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program. ☐  
I have participated in the development of this Plan of Care and agree with it. ☐

Recipient: \_\_\_\_\_ Legal Representative: \_\_\_\_\_  
(Signature) (Date) (Signature) (Date)

Significant Other: \_\_\_\_\_ CMT Staff: \_\_\_\_\_  
(Signature) (Date) (Signature) (Date)

Health Care Professional: \_\_\_\_\_  
(Signature) (Date)





Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Intake Sheet (DPHHS-MA-136)  
Instructions

**PURPOSE:** The Case Management Team (CMT) completes this form for each recipient upon admission to Home and Community Based Services (HCBS), or when a recipient changes care categories or changes eligibility category. The purpose of the Intake Sheet is to meet federal tracking requirements.

**DISTRIBUTION:** The white copy is sent to the Department and the yellow copy is retained by the CMT for its files. Intake Sheets for overcost care plans are sent to the Department via the RPO who must sign off on them.

**INSTRUCTIONS:** Recipient Information--Enter last name, first name, Medicaid number, date of birth, sex and marital status.

CMT #-- Enter Case Management Team's provider number. Include all six digits (xx-xxxx).

County #--Enter the county number where the recipient resides.

- |                |                   |
|----------------|-------------------|
| 1. Beaverhead  | 17. Garfield      |
| 2. Big Horn    | 18. Glacier       |
| 3. Blaine      | 19. Golden Valley |
| 4. Broadwater  | 20. Granite       |
| 5. Carbon      | 21. Hill          |
| 6. Carter      | 22. Jefferson     |
| 7. Cascade     | 23. Judith Basin  |
| 8. Choteau     | 24. Lake          |
| 9. Custer      | 25. Lewis & Clark |
| 10. Daniels    | 26. Liberty       |
| 11. Dawson     | 27. Lincoln       |
| 12. Deer Lodge | 28. Madison       |
| 13. Fallon     | 29. McCone        |
| 14. Fergus     | 30. Meagher       |
| 15. Flathead   | 31. Mineral       |
| 16. Gallatin   | 32. Missoula      |

## SECTION:

APPENDIX

## SUBJECT:

Intake Sheet (DPHHS-MA-136)  
Instructions

- |                  |                 |
|------------------|-----------------|
| 33. Musselshell  | 47. Silver Bow  |
| 34. Park         | 48. Stillwater  |
| 35. Petroleum    | 49. Sweetgrass  |
| 36. Phillips     | 50. Teton       |
| 37. Pondera      | 51. Toole       |
| 38. Powder River | 52. Treasure    |
| 39. Powell       | 53. Valley      |
| 40. Prairie      | 54. Wheatland   |
| 41. Ravalli      | 55. Wibaux      |
| 42. Richland     | 56. Yellowstone |
| 43. Roosevelt    |                 |
| 44. Rosebud      |                 |
| 45. Sanders      |                 |
| 46. Sheridan     |                 |

Referral Date--Enter the date the most current referral was made.

Referral Source #--Enter the corresponding number for referral source.

1. Regional Program Officer
2. Self
3. Family
4. Hospital
5. Nursing Home
6. Health Care Professional
7. County Health Department
8. Home Health Agency
9. Hospice
10. Mountain Pacific Quality Health Foundation
11. Eligibility Technician
12. County Social Services
13. Area Agency on Aging
14. Other Agency
15. Non-Relative
16. Group Residence
17. Other

Admit Date--Enter date recipient was admitted to HCBS. This must be the same date as the effective date on the DPHHS-DD/MA-55 form. If the Eligibility Staff designates a different date due to

## SECTION:

## APPENDIX

## SUBJECT:

Intake Sheet (DPHHS-MA-136)  
Instructions

Medicaid eligibility, the CMT must use the eligibility date as the admit date. If the Intake Sheet has already been sent to the Department, change the admit date on the yellow copy of the Intake Sheet, photo copy the corrected Intake Sheet and forward the photo copy to the Department.

Readmit Date--Enter date readmitted to HCBS. This must be the same date as the effective date on the DPHHS-DD/MA-55 form.

Pay Status--Enter "X" after appropriate category.

Residential Status Prior to HCBS--Circle recipient's residential status prior to the time of entry to HCBS.

Service Setting Under HCBS--Circle the appropriate setting in which HCBS services are being provided.

Care Category--Enter "X" next to level of care.

Eligibility Category--Enter "X" next to appropriate category.

Plan of Care Cost--Enter the total plan of care cost. Enter dollars only - no cents.

Over Cost-RPO Initial--The Intake Sheet for recipients with over cost plans of care must be initialed by the RPO. The RPO will forward the Intake Sheet to the Department.

Diagnosis--Circle primary diagnosis only.

Activities of Daily Living--Circle all that apply.

Signature--The person completing this intake sheet should sign and date the form.

For changes in care categories--Fill out a Discharge Sheet. Check the discharge is a result of care category change section. Complete a new Intake Sheet and send to the Department.

## SECTION:

APPENDIX

## SUBJECT:

Intake Sheet (DPHHS-MA-136)  
Instructions

For changes in eligibility category--Make a copy of the original Intake Sheet, cross out previous category, check off and circle new eligibility category indicating the date the recipient changed categories. Make copy of changed Intake Sheet and send to the Department.

o o o



HOME AND COMMUNITY BASED SERVICES  
INTAKE SHEETRECIPIENT NAME: \_\_\_\_\_  
(Last) (First)

MEDICAID ID#: \_\_\_\_\_ CMT #: \_\_\_\_\_ RECIPIENT COUNTY #: \_\_\_\_\_

CURRENT REFERRAL DATE: \_\_\_\_\_ CURRENT REFERRAL SOURCE #: \_\_\_\_\_

ADMIT DATE: \_\_\_\_\_ READMIT DATE: \_\_\_\_\_

PAY STATUS: (1) Medicaid \_\_\_\_\_ (2) Medically Needy \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: (1) Male \_\_\_\_\_ (2) Female \_\_\_\_\_

MARITAL STATUS: (1) Single \_\_\_\_\_ (2) Married \_\_\_\_\_ (3) Divorced/Widowed/Separated \_\_\_\_\_

## RESIDENTIAL STATUS PRIOR TO HCBS: (Circle One)

- |                        |  |
|------------------------|--|
| 1. Institution         | (1) Nursing Facility                     |
| 2. Private Residence   | (1) Lives Alone                          |
|                        | (2) Lives with Parents or Adult Children |
|                        | (3) Lives with Spouse                    |
|                        | (4) Shared Living with Relatives         |
|                        | (5) Shared Living with Non-relatives     |
| Group Residence        | (1) Adult Residential                    |
|                        | (2) Group Home                           |
|                        | (3) Retirement Home                      |
| 4. Acute Care Hospital | (1) From Nursing Facility                |
|                        | (2) From Private Residence               |
|                        | (3) From Group Residence                 |

SERVICE SETTING UNDER HCBS:  
(Circle One)

- |                              |
|------------------------------|
| (1) Adult Foster Home        |
| (2) Personal Care Facility   |
| (3) Residential Hospice      |
| (4) Supported Living         |
| (5) Other                    |
| (6) AR/TBI                   |
| (7) Residential Habilitation |
| (8) Group Home               |
| (9) Bridges/Headway          |

CARE CATEGORY: (3) Hospital (CC3) \_\_\_\_\_ (4) Nursing Facility (CC1 &amp; CC2) \_\_\_\_\_

ELIGIBILITY CATEGORY: (1) Elderly \_\_\_\_\_ (2) Disabled \_\_\_\_\_

PLAN OF CARE COST: \$ \_\_\_\_\_ Over Cost - RPO Initial \_\_\_\_\_

## DIAGNOSIS: (Circle Primary Diagnosis Only)

- |   |                                      |
|---|--------------------------------------|
| (1) Mental Disorders (290-319)  | (6) Respiratory Disorders (460-519)  |
| (2) Cancer, Digestive, Blood, Metabolic and Genitourinary Disorders (140-239, 520-579, 280-289, 270-279, 580-629) | (7) Injury (800-959)                 |
| (3) Circulatory Disorders (390-459)   | (8) Other (1-139, 240-269, 740-799)  |
| (4) Nervous Disorders (320-389)   | (9) HIV-Related Disorders (042-44.9) |
| (5) Musculoskeletal Disorders (710-739)   |                                      |

## ACTIVITIES OF DAILY LIVING: (Circle All That Apply)

- |  |   |
|--|---|
| (1) Help with Mobility and/or Transfer | (4) Help with Eating and/or Feeding         |
| (2) Help with Grooming and/or Dressing | (5) Help with Household Management          |
| Help with Bathing and/or Toileting     | (6) Help with Self-Administered Medications |

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date



## HOME AND COMMUNITY BASED SERVICES INTAKE SHEET

RECIPIENT NAME: \_\_\_\_\_  
(Last)
(First)

MEDICAID ID#: \_\_\_\_\_ CMT #: \_\_\_\_\_ - \_\_\_\_\_ RECIPIENT COUNTY #: \_\_\_\_\_

CURRENT REFERRAL DATE: \_\_\_\_\_ CURRENT REFERRAL SOURCE #: \_\_\_\_\_

ADMIT DATE: \_\_\_\_\_ READMIT DATE: \_\_\_\_\_

PAY STATUS: (1) Medicaid \_\_\_\_\_ (2) Medically Needy \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: (1) Male \_\_\_\_\_ (2) Female \_\_\_\_\_

MARITAL STATUS: (1) Single \_\_\_\_\_ (2) Married \_\_\_\_\_ (3) Divorced/Widowed/Separated \_\_\_\_\_

### RESIDENTIAL STATUS PRIOR TO HCBS: (Circle One)

- |                        |  |
|------------------------|--|
| 1. Institution         | (1) Nursing Facility                     |
| 2. Private Residence   | (1) Lives Alone                          |
|                        | (2) Lives with Parents or Adult Children |
|                        | (3) Lives with Spouse                    |
|                        | (4) Shared Living with Relatives         |
|                        | (5) Shared Living with Non-relatives     |
| 3. Group Residence     | (1) Adult Residential                    |
|                        | (2) Group Home                           |
|                        | (3) Retirement Home                      |
| 4. Acute Care Hospital | (1) From Nursing Facility                |
|                        | (2) From Private Residence               |
|                        | (3) From Group Residence                 |

### SERVICE SETTING UNDER HCBS: (Circle One)

- |                            |
|----------------------------|
| (1) Foster Home            |
| (2) Personal Care Facility |
| (3) Residential Hospice    |
| (4) Supported Living       |
| (5) Other                  |

CARE CATEGORY: (3) Hospital (CC3) \_\_\_\_\_ (4) Nursing Facility (CC1 & CC2) \_\_\_\_\_

ELIGIBILITY CATEGORY: (1) Elderly \_\_\_\_\_ (2) Disabled \_\_\_\_\_

PLAN OF CARE COST: \$ \_\_\_\_\_ Over Cost - RPO Initial \_\_\_\_\_

### DIAGNOSIS: (Circle Primary Diagnosis Only)

- |   |                                      |
|---|--------------------------------------|
| (1) Mental Disorders (290-319)  | (6) Respiratory Disorders (460-519)  |
| (2) Cancer, Digestive, Blood, Metabolic and Genitourinary Disorders (140-239, 520-579, 280-289, 270-279, 580-629) | (7) Injury (800-959)                 |
| (3) Circulatory Disorders (390-459)   | (8) Other (1-139, 240-269, 740-799)  |
| (4) Nervous Disorders (320-389)   | (9) HIV-Related Disorders (042-44.9) |
| (5) Musculoskeletal Disorders (710-739)   |                                      |

### ACTIVITIES OF DAILY LIVING: (Circle All That Apply)

- |  |   |
|--|---|
| (1) Help with Mobility and/or Transfer | (4) Help with Eating and/or Feeding         |
| (2) Help with Grooming and/or Dressing | (5) Help with Household Management          |
| Help with Bathing and/or Toileting     | (6) Help with Self-Administered Medications |

Signature \_\_\_\_\_

Date \_\_\_\_\_





**SECTION  
APPENDIX****SUBJECT  
DISCHARGE SHEET (DPHHS-SLTC-137) INSTRUCTIONS****PURPOSE**

The case management team (CMT) completes this form for each consumer upon discharge to Home and Community Based Services (HCBS), or when a consumer changes care category.

**DISTRIBUTION**

The original is faxed to the Foundation and retained by the CMT for its files. The fax number is 800-413-3890 and in Helena 443-4585.

**INSTRUCTIONS**

Consumer Information--Enter last name, first name and Medicaid ID number.

Case Management Team No.--Enter Case Management Team's seven digit provider number.

Community Medical Center	0600080
Partners in Home Care	0612300
Yellowstone City-Co Health Dept	0620160
Easter Seals	0630136
District IX HRDC	0642018
L&C City-Co Health Dept	0650000
Holy Rosary Hospital	0660010
Sidney Health Center	0670007
NW MT Human Resources	0680004
Area IX AOA	0681139
Spectrum Medical, Inc.	0690115
Central MT Medical Center	0700024
Area II AOA	0800003
Area VI AOA	0810004
Area VIII AOA	0820001
Area X AOA	0830008
Area XI AOA	0840004
Area IV AOA	0850434
Area III AOA	0860013
Area V AOA	0870009





**SECTION**  
**APPENDIX**

**SUBJECT**  
**DISCHARGE SHEET (DPHHS-SLTC-137) INSTRUCTIONS**

Most Recent Admit Date--Enter date of *most recent enrollment*.

Discharge Date--Enter date of discharge. This must be the same date as the effective date when HCBS is terminated on the DPHHS-DD/SLTC-55 form.

Discharge Code--Circle the number corresponding to reason for discharge.

Check appropriate line if discharge is the result of a care category change. Submit a new Intake Sheet.

Provider Notification—This form may be used to notify providers of the discharge date. Enter the provider agency and date notice was sent.

Signature--The person completing this Discharge Sheet should sign and date the form.





**HOME AND COMMUNITY BASED SERVICES  
DISCHARGE SHEET**

**Fax to: 1-800-413-3890 or 406-443-4585**

Consumer Name: \_\_\_\_\_  
(Last) (First)

Consumer Medicaid Id#: \_\_\_\_\_ CMT/IA Provider Number: \_\_\_\_\_

Most Recent Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**DISCHARGE CODE: (Circle One)**

- |   |                             |    |  |
|---|-----------------------------|----|--|
| 1 | Death                       | 9  | Other (Specify) _____                            |
| 2 | Nursing Home Placement      |    | _____  |
| 3 | Hospital Placement          | 10 | No Longer Meets Level of Care                    |
| 4 | No Longer Requires Services | 11 | Care Category Change *                           |
| 5 | Medicaid Ineligibility      | 12 | Moved to SDMI Waiver                             |
| 6 | Moved From Service Area     | 13 | Year-End Money Completed                         |
| 7 | Exceeded Cost Limit         | 14 | Moved to Big Sky Bonanza from Traditional Waiver |
| 8 | Voluntary Disenrollment     | 15 | Moved to Traditional Waiver from Big Sky Bonanza |

\* Submit a new Intake Sheet with updated information.

**PROVIDER NOTIFICATION**

**DATE**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Personal Assistance Services HCBS  
Referral/Amendment (DPHHS-MA-138)  
Instructions

CMT'S RELATIONSHIP  
TO PERSONAL ASSISTANCE

AGENCY: It is the Case Management Team's (CMT) responsibility to develop and monitor Home and Community Based Service (HCBS) plans of care for all recipients enrolled in the HCBS Program. The CMT must arrange for HCBS related personal assistance services through the enrolled provider agency. (Refer to HCBS 518.)

PURPOSE: CMTs use this form to request waiver personal care services or to amend current waiver personal care services.

PROCEDURE: CMT completes this form and then sends it to the recipient's choice of personal care provider agency.

DISTRIBUTION: White and yellow copies sent to personal care provider agency. CMT retains pink copy.

INSTRUCTIONS: Check box to indicate whether this is an initial referral or an amendment to current services. Check box to indicate whether this is an emergency referral or not. If you check "yes", please document in comment section reason why.

Identifying Information--If this is an initial referral, complete all identifying information (Recipient Name through Medical Diagnosis). If this is referral for amended services you need only fill in the Recipient Name and Medicaid #. EXCEPTION: Please give any identifying information which may have changed from last referral.

HCBS Services Requested--Check which HCBS personal care service(s) are being requested. Indicate the time period on each day of the week that the recipient is requesting the

SECTION:	SUBJECT:
APPENDIX	Personal Assistance Services HCBS Referral/Amendment (DPHHS-MA-138) Instructions

service and the total weekly number for each service. (For instance: Socialization: 2PM-4PM Monday and Friday, weekly total-4 hours.) If Social Transportation is checked, please indicate the PA dates and the weekly mileage.

Need for services--Document reason services are being requested.

Comments--Document any information pertinent to this referral. If this recipient is currently receiving state plan personal care services, please list the number of weekly hours (if you know) and the agency that is providing these hours. Also, list other services that are being provided, such as home health.

Referred By--Fill in referral information.

#### RESPONSIBILITY

#### ACTION

Case Management  
Team:

Complete the Personal Assistance Services HCBS Referral/Amendment Form (DPHHS-MA-138) and send it to the appropriate provider agency. Attach a copy of the HCBS Plan of Care (DPHHS-MA-135) to the referral form. If all signatures have not yet been obtained on the HCBS Plan of Care, the referral can be sent without it, but a copy of the plan of care must be forwarded as soon as all signatures are obtained.

Personal Assistance

Provider Agency: Visit the recipient's home to complete the Personal Assistance Services Plan/Physician Order (DPHHS-MA-140). The provider agency does not obtain physician's orders for HCBS referrals since these are included in the HCBS plan of care.

Send a copy of the Personal Assistance Services Plan/Physician Order (DPHHS-MA-140) to the CMT. Discuss all proposed changes to the Personal Assistance Service Plan/Physician

SECTION:

APPENDIX

SUBJECT:

Personal Assistance Services  
HCBS Referral/Amendment  
(DPHHS-MA-138) Instructions

Order with the CMT prior to changing what the CMT requested on the Personal Assistance Services HCBS Referral/Amendment Form.

EMERGENCY  
REFERRALS:

In the case of emergency referrals, the CMT should contact the provider agency immediately. The provider agency will coordinate with the local nurse supervisor to implement services as soon as possible. Emergency requests should be limited to recipients who are at immediate risk of institutionalization or in a hazardous home situation.

REASSESSMENTS:

The CMT should keep the provider agency informed of all changes effecting the recipient's need for HCBS related personal assistance. Notification of changes can be made on the HCBS Reevaluation Form (DPHHS-MA-139) and the HCBS Amendment Form (DPHHS-MA-141), and notification of discharge on the HCBS Discharge Sheet (DPHHS-MA-137).

NOTE: State Plan personal assistance services are determined by the personal assistance provider agency.

o o o



<input type="checkbox"/> HCBS Referral	<input type="checkbox"/> HCBS Amendment	Emergency Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	--

**Recipient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** M F

**Address:** \_\_\_\_\_  
                     (Street)                                  (City)                                  (Zip Code)                                  (Phone No.)

**Living Arrangements:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Significant Other(s)** (include name, address, phone & relationship): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

---

**Medicaid No:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Incurment Amount:** \_\_\_\_\_

**Month(s) of Medicaid Eligibility:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

**Medical Diagnoses:** \_\_\_\_\_  
 \_\_\_\_\_

---

**Prior Authorization No:** \_\_\_\_\_ **PA Dates:** \_\_\_\_\_

HCBS SERVICES REQUESTED:	SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS
Socialization								
Supervision								
Specialized Trained Attendants								
Social Transportation								

**Mileage:** \_\_\_\_\_

**Need for services:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

---

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

---

**Weekly hours of state plan recipient is receiving:** \_\_\_\_\_

**Other services in place:** \_\_\_\_\_  
 \_\_\_\_\_

---

**Referred to Agency:** \_\_\_\_\_

**Referred By:**    **Team:** \_\_\_\_\_    **Individual** \_\_\_\_\_

**Phone:** \_\_\_\_\_    **Date:** \_\_\_\_\_

---

**TO BE COMPLETED BY PERSONAL ASSISTANCE AGENCY**

---

**Date referral received:** \_\_\_\_\_    **Date of initiation of care:** \_\_\_\_\_

**Referral source follow up date:** \_\_\_\_\_

**PERSONAL CARE SERVICES  
HCBS REFERRAL/AMENDMENT FORM**

<input type="checkbox"/> HCBS Referral		<input type="checkbox"/> HCBS Amendment		Emergency Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Recipient Name: _____ D.O.B. _____ Age: _____ Sex: M F									
Address: _____ (Street) (City) (Zip Code) (Phone No.)									
Living Arrangements: _____ Marital Status: _____									
Significant Other(s) (include name, address, phone & relationship): _____ _____ _____									
Medicaid No: _____ County: _____ Incurment Amount: _____									
Month(s) of Medicaid Eligibility: _____									
Physician: _____ Address: _____ Phone No.: _____									
Medical Diagnoses: _____ _____ _____									
Prior Authorization No: _____ PA Dates: _____									
HCBS SERVICES REQUESTED:		SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL HRS
Socialization									
Supervision									
Specialized Trained Attendants									
Social Transportation									Mileage: _____
Need for services: _____ _____ _____									
Comments: _____ _____ _____ _____ _____									
Weekly hours of state plan recipient is receiving: _____									
Other services in place: _____ _____ _____									
Referred to Agency: _____									
Referred By: Team: _____ Individual _____									
Phone: _____ Date: _____									
<b>TO BE COMPLETED BY PERSONAL CARE AGENCY</b>									
Referral received: _____ Date of initiation of care: _____									
Referral source follow up date: _____									





Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Reevaluation Form (DPHHS-MA-  
139) Instructions

**PURPOSE:** The reevaluation form is to be completed by the Case Management Team (CMT) six months after the annual plan of care.

**DISTRIBUTION:** The CMT retains this form for its files.

**INSTRUCTIONS:** Recipient Information--Enter the recipient's name and Medicaid number.

Reevaluation Date--Enter the date when the reevaluation was completed.

Date of Last Care Plan--Enter the date of the current care plan.

Dates of Amendments--Enter dates of all amendments completed since last care plan.

Recipient's Comments--Report recipient's comments concerning the services received. You may also include general comments pertinent to the delivery of services. For example, change in health status, family support, living conditions, etc.

On-site Visit Required: Date--Enter the date the nurse and the social worker made the on-site visit to the recipient to do the reevaluation.

New Orders or Comments--Report any new orders or comments from the attending health care professional since the last care plan.

Health Care Professional Contact: Date--Enter dates of contact.

Contact Made with Service Providers--List contacts made by the CMT.

SECTION:	SUBJECT:
----------	----------

APPENDIX	Reevaluation Form (DPHHS-MA-139) Instructions
----------	--

Summary--Summarize recipient's medical and social status as it relates to the service delivery plan.

Discharge Plan--The CMT must address the recipient's discharge potential and plan from HCBS. For example, a recipient may have good discharge potential with continued strong family support. Individuals are to be discharged from services as soon as possible.

Signature--The nurse and social worker who are completing the reevaluation should sign and date the form.

o o o

**HOME AND COMMUNITY BASED SERVICES  
REEVALUATION FORM**

Recipient Name:		Medicaid No:
Reevaluation date:	Date of last Care Plan:	Dates of amendments: (Since last care plan)
Recipient comments:		Required on-site visit completed: Date _____
New orders or comments:		Physician contact: Date _____
Contacts made to complete six month reevaluation (give name of contact, relationship to recipient, date contacted and comments).		
Summary:		
Discharge Plan update:		
Nurse: _____ Date: _____		
Social Worker: _____ Date: _____		





Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Amendment Form (DPHHS-MA-141)  
Instructions

**PURPOSE:** This form is used to amend a care plan or an existing prior authorization. This allows the Case Management Team (CMT) to make corrections, add or delete services without completing a new care plan or a new request for prior authorization. The CMT will complete the amendment portion of the form.

**DISTRIBUTION:** For an amendment to the plan of care, the CMT will retain the white copy and send the yellow copy to the recipient. For an amendment to a prior authorization, the CMT sends the form to the Regional Program Officer (RPO) for signature. The RPO will complete the bottom section and return the form to the CMT. A copy will need to be sent to the Community Services Section for Care Category 3 (CC3). The CMT retains the white copy for their file and sends the recipient the yellow copy.

**INSTRUCTIONS:** Recipient Name--Enter name of the recipient.

Medicaid ID Number--Enter the Medicaid number of the recipient.

Date of Last Care Plan--Enter the date of the current care plan.

Amendment Date--Enter the date of the amendment(s).

Cost Sheet Attached--This is a reminder to attach cost sheet which is required with each amendment.

Services Amended--List services amended and the frequency that the service will be provided.

## SECTION:

APPENDIX

## SUBJECT:

Amendment Form (DPHHS-MA-141)  
Instructions

Reason for Amendment--List the reason(s) for the amendment.

Comments--This space is to be used for further explanation if necessary.

Signature--The nurse and the social worker who are completing the amendment should sign and date the form.

Amendment to Prior Authorization Section--Effective April 1, 1996, the Case Management Team does not complete this section.

Regional Program Officer Concurs--The RPO will mark yes if they concur with the request to amend a prior authorization and no if they do not. If the RPO does not concur, they will need to contact the CMT and explain the reason for the denial.

Medicaid Services Division Concurs--Effective April 1, 1996, the form is not sent to the Community Services Bureau for signature. However, for CC3 the RPO will send a copy.

WHEN A NEW PLAN OF CARE IS DEVELOPED, A NEW PRIOR AUTHORIZATION MUST BE COMPLETED IF REQUIRED.

o o o

**HOME AND COMMUNITY BASED SERVICES  
AMENDMENT FORM**

Recipient Name

Medicaid Number

**TO BE COMPLETED BY CASE MANAGEMENT TEAM**

Date of Last Care Plan

Amendment Date

Cost Sheet Attached \_\_\_\_\_

Services Amended:

Reason for Amendment:

Comments:

Nurse: \_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)Social Worker: \_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)**IF YOU DISAGREE WITH THIS AMENDMENT, YOU MAY REQUEST A FAIR HEARING BEFORE A HEARING OFFICER OF THE BOARD OF PUBLIC ASSISTANCE. CONTACT YOUR CASE MANAGEMENT TEAM.****AMENDMENT TO PRIOR AUTHORIZATION**

Reason for Amendment:

Nurse:

\_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)

Social Worker:

\_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)

Regional Program Officer Concurs:

☐ Yes ☐ No\_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)

Medicaid Services Division Concurs:

☐ Yes ☐ No\_\_\_\_\_  
(Signature)\_\_\_\_\_  
(Date)



Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Psychosocial Summary  
(DPHHS-MA-143) Instructions

- PURPOSE:** To provide an assessment of a recipient's psychosocial status. The social worker on the Case Management Team (CMT) completes this form upon the initial assessment for the recipient's enrollment in Home and Community Based Services (HCBS). Annual updates to the psychosocial summary should be included in the assessment summary section of the plan of care. A new Psychosocial Summary Form is not required.
- DISTRIBUTION:** Only one copy of the Psychosocial Summary Form is required. The CMT social worker signs and dates the form upon completion. Attach the Psychosocial Summary Form to the initial plan of care. Psychosocial information does not need to be sent to the recipient for review.
- INSTRUCTIONS:** Name--Enter the name of the recipient.
- Medicaid Number (SSN)--Enter the recipient's Medicaid number.
- Presenting Problem--Summarize the need for HCBS. The summary should contain a brief history of the events leading to the need for HCBS, including health, social, psychological, economic, family, and any other factors pertaining to the need for HCBS.
- Personal History--Summarize the recipient's personal history. This should include information on childhood and family history, family dynamics, marital history, education, and employment. This is not meant to be an in-depth study, but rather a general portrait of the recipient.



## SECTION:

APPENDIX

## SUBJECT:

Psychosocial Summary  
(DPHHS-MA-143) Instructions

Psychosocial Summary--Assess the recipient's ability to cope with illness/disability and surroundings. Describe the recipient's

understanding and acceptance of the illness/disability and any impacts this may have on them or family. This summary is further broken down into three areas as follows:

Social Assessment--Describe how the recipient functions socially, i.e., within the family and community. Do they enjoy the company of family or friends in the home or activities outside of the home? In what type of outside activities does the recipient engage? Does the recipient relate easily to family, friends, professionals, or is there difficulty in getting along with others? Is the recipient accepting of others and do others accept the recipient?

Emotional Assessment--Does the recipient display an abundance of emotions or no emotions at all? Describe the emotional state of the recipient. Which emotion appears dominant? Which emotions appear repressed? Does recipient appear to be emotionally stable or labile?

Mental Assessment--Summarize the mental status of the recipient. This should include any significant history of mental problems. Is the recipient adjusted to their life and comfortable with their life situation? Is their behavior appropriate and not causing conflict with others? Address the recipient's feelings of self-esteem and ability to cope with their life. Is the recipient grieving?

Current Living Situation--Describe where and how the recipient lives. Are they living alone by choice, in a relative's home by choice, in an NF setting, etc. Describe the environment they are currently living in. This category is broken down further into the following:

## SECTION:

## APPENDIX

## SUBJECT:

Psychosocial Summary  
(DPHHS-MA-143) Instructions

Financial Assessment--Describe sources of income. Is the recipient's income adequate to cover expenses? Are any referrals appropriate, such as food stamps application, housing assistance, or other community resources? Is the recipient able to manage their own finances? Evaluate the need for POA, guardian, conservator or payee.

Home--Describe the recipient's physical living environment. Is the living arrangement temporary or permanent? Are there any safety concerns? Are there any environmental modification needs? Is the home energy efficient, or should recipient seek assistance from LIEAP. Is the recipient willing to accept any needed changes? Are there any family or community resources available to assist with these needs?

Transportation--Describe recipient's transportation needs and current means of transportation. Is the recipient dependent on others for transportation? Is the recipient able to arrange for transportation? Does the recipient have any special transportation needs? Are there any family or community resources available to assist with transportation needs?

Medical Compliance--Describe the recipient's medical compliance. Is the recipient willing and or able to manage medical directives from physician or other health care professionals? Is the recipient willing and/or able to manage procurement and administration of medicines, treatments or therapies? Is there a need for assistance with medical compliance? Is the recipient willing to accept assistance? Are there any family or community resources available to help?

Support Systems--Describe the recipient's support systems. Is there a primary caregiver? Is the primary caregiver willing and able to continue in this role? Are there any

## SECTION:

APPENDIX

## SUBJECT:

Psychosocial Summary  
(DPHHS-MA-143) Instructions

other family, friends, volunteers who provide support to the recipient? Does the recipient pay privately for any supportive services? Is there a need to seek out supportive services for the recipient? This section should include a description of the family's understanding and acceptance of the recipient's illness/disability.

Neglect/Abuse--Is there any evidence of neglect or abuse? This includes physical, emotional, mental or financial abuse or neglect. Evaluate the need to report neglect or abuse to the proper authorities.

Long-Term Planning--Has the recipient made any plans for the future? Consider the following areas: living arrangements (alone, with family, NF etc.), financial arrangements (will, burial plans, etc.), advance directives (living will, Durable POA, etc.). Evaluate the recipient's need for long-term planning. Is the recipient willing to accept assistance with long-term planning? Are there any available family or community resources to assist with long-term planning?

Comments and Impressions--Briefly summarize all of the information gathered. Include any comments or impressions that have not been previously stated. Include goals and treatment plans to accomplish goals. Include the recipient's willingness to comply with the goals and treatment plan.

Signature and Date--The CMT social worker signs the psychosocial summary and dates it the day it is written.

o o o

**HOME AND COMMUNITY BASED SERVICES  
PSYCHOSOCIAL SUMMARY****I. IDENTIFYING INFORMATION:**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

**II. PRESENTING PROBLEM (include summary of need for HCBS services and health history):****IV. PERSONAL HISTORY (include family history/dynamics, marital history, education, employment and leisure activities):****V. PSYCHOSOCIAL SUMMARY (include assessment of coping skills, patient understanding/acceptance of illness, cognitive abilities and mental status):**



Name \_\_\_\_\_

Date \_\_\_\_\_

A. Social Assessment:

B. Emotional Assessment:

C. Mental Assessment:

**VI. CURRENT LIVING SITUATION:**

A. Financial Assessment:

B. Home:



Name \_\_\_\_\_

Date \_\_\_\_\_

Transportation:

D. Medical Compliance:

E. Support Systems (include family understanding/acceptance of illness):

F. Neglect/Abuse:

G. Long Term Planning:

**VII. COMMENTS AND IMPRESSIONS:**

Signature \_\_\_\_\_

Date \_\_\_\_\_



Department of Public Health  
and Human Services

SECTION:  
APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Letter of Notification  
(DPHHS-MA-144) Instructions

**PURPOSE:** The Case Management Team (CMT) uses this form to notify recipients being discharged from Home and Community Based Services (HCBS), explains the reason for the discharge, and notifies recipients of their Fair Hearing rights. The recipient may request a Fair Hearing by filling out the bottom portion of the form and mailing it to the Fair Hearings Office.

**DISTRIBUTION:** White copy is sent to the recipient. CMT retains the yellow copy. Regional Program Officer (RPO), when applicable, retains the pink copy.

**INSTRUCTIONS:**

**TO:--**List the name, complete mailing address and phone number of the HCBS recipient.

**FROM:--**List the name, complete address and phone number of the HCBS Case Management Team issuing the notification.

**ACTION--**Check reason for the discharge and give date of discharge. If reason "C" is checked, the CMT will contact the RPO for review. If the RPO concurs with the discharge, the CMT will explain the reason for the termination in this section and give effective date of discharge. **NOTE:** Since this is an adverse action, you must give the recipient ten days notice prior to discharge.

**Signatures--**If discharge was for reason "A" or "B", the case manager signs and dates the form and mails the white copy to the recipient. If discharge was for reason "C", both the case manager and the RPO must sign and date the form prior to distribution.

o o o



**HOME AND COMMUNITY BASED SERVICES  
LETTER OF NOTIFICATION**

TO:	Name & Address	FROM:	Name, Address & Phone Number
-----	----------------	-------	------------------------------

**ACTION:**

- ☐ A. You are being discharged effective \_\_\_\_\_ from the Home & Community Based Services program per your request.
- ☐ B. You are being discharged effective \_\_\_\_\_ from the Home & Community Based Services program because of nursing facility or hospital placement.
- ☐ C. Other:

Legal Basis for Action:

ARM 46.12.1413

42 CFR Part 431 Subpart E

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. **(PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

Name

Case Management Team

(Date)

If you were terminated for reason C, a Regional Program Officer with Medicaid has been consulted and is in agreement with this decision.

Regional Program Officer

(Date)

**REQUEST FOR FAIR HEARING**

I request a fair hearing for these reasons: \_\_\_\_\_

I have an attorney: [ ] YES [ ] NO My attorney's name is: \_\_\_\_\_

Attorney's address: \_\_\_\_\_

Attorney's phone number: \_\_\_\_\_

(Claimant or Authorized Representative)

(Phone)

(Date)

To request a fair hearing complete, sign and mail the white copy of this notice to: Hearing Office, P.O. Box 4210, Helena, MT 59604.



## IMPORTANT

If you disagree with the determination stated on this form you may request a fair hearing before a hearing officer of the Board of Public Assistance.

Under certain circumstances you may continue to receive services during the period of your appeal. A request for continuation of services must be made prior to the date given in the notice of the change in, or termination of, your services. If you are interested in continuing to receive services during the period of your appeal, you must contact one of the regional program officers listed below immediately to request continuation of services.

A request for fair hearing must be made in writing within 90 days of the mailing date of this notice. You may use the "Request for Fair Hearing" section on the front section of this form to make your request. A request for fair hearing must be directed to:

Hearing Officer  
P.O. Box 4210  
Helena, MT 59604

If you need assistance in preparing a request for fair hearing you may contact one of the regional program officers listed below.

Prior to the fair hearing, a program officer for the Department will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity for you to informally present your case and for the Department to reconsider the matters that you are appealing.

The fair hearing is a process in which the parties formally present their legal arguments and evidence in support of their positions on the matters at issue. The decision of the hearing officer is made based on the evidence presented at hearing and upon the governing federal and state laws, regulations and policies. The decision of the hearing officer may be appealed to the Board of Public Assistance. The Board of Public Assistance reviews the matters at issue as presented before the hearing officer. This appeal does not involve another hearing. The decision of the hearing officer or the Board of Public Assistance resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.

### REGIONAL PROGRAM OFFICERS

Regional Program Officer  
P.O. Box 2357  
Kalispell, MT 59903  
Phone: 755-5420

Lincoln, Flathead, Sanders,  
Lake

Regional Program Officer  
700 Casey  
Butte, MT 59701  
Phone: 496-4989

Silver Bow, Deer Lodge,  
Granite, Beaverhead

Regional Program Officer  
1610 S 3rd W Suite 202  
Missoula, MT 59801  
Phone: 329-5426

Missoula, Ravalli, Mineral

Regional Program Officer  
1211 Grand Avenue  
Billings, MT 59102  
Phone: 254-0331

Yellowstone, Big Horn,  
Carbon, Mussellshell, Golden  
Valley, Stillwater, Wheatland,  
Treasure

Regional Program Officer  
3075 N. Montana Ave  
Helena, MT 59601  
Phone: 444-1707

Lewis and Clark, Jefferson,  
Meagher, Broadwater,  
Powell, MT State Hospital  
Long Term Care Unit

Regional Program Officer  
207 West Bell  
Glendive, MT 59330  
Phone: 365-6252

Powder River, Carter, Custer,  
Fallon, Rosebud, Garfield,  
Prairie, Wibaux, Dawson,  
McCone, Richland, Roosevelt,  
Sheridan, Daniels, Valley

Regional Program Officer  
1824 10th Ave S  
Great Falls, MT 59403  
Phone: 453-8902  
453-8975

Cascade, Teton, Pondera, Hill,  
Chouteau, Judith Basin, Phillips,  
Fergus, Petroleum, Glacier,  
Toole, Liberty, Blaine

Regional Program Officer  
202 South Black  
Bozeman, MT 59715  
Phone: 586-7969

Gallatin, Sweetgrass, Park,  
Madison

Department of Public Health  
and Human Services

**SECTION:**

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

**SUBJECT:**

Level I Screen (DPHHS-MA-145)  
Instructions

**PURPOSE:**

This form is required prior to admission to a nursing facility or the Home and Community Based Services (HCBS) program. It is used to identify persons with indications or diagnosis of mental illness (MI) or mental retardation (MR) or related conditions.

The Case Management Teams (CMT) should initiate this form at the same time they initiate a Level of Care referral. **The CMT need only provide the information that is readily available to them.** The Mountain Pacific Quality Health Foundation will gather any additional information needed to complete the form.

**INSTRUCTIONS:**

Identifying Information--Fill in any information in the first block that is available when making the referral. If this is a referral for HCBS, indicate this in place of the name of the nursing facility.

Section "A" and "C"--Complete these sections with the information that you have available to you. Detailed instructions are as follows:

- A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment;

and as a result of the diagnosed mental condition, the applicant presently suffers from significant impairment in at least two of the following functional areas:



## SECTION:

APPENDIX

## SUBJECT:

Level I Screen (DPHHS-MA-145)  
Instructions

1. ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;
2. ability to maintain community living without dependence on public support systems and monitoring;
3. ability to develop and maintain personal relationships and support systems;
4. ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities;

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required by these persons. It is manifested before the person reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations

**SECTION:**

APPENDIX

**SUBJECT:**Level I Screen (DPHHS-MA-145)  
Instructions

in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

C. Self-explanatory.

D. Do not fill out. For Foundation use only.

E. Do not fill out. For Foundation use only.

o o o





# LEVEL I SCREEN

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM FOR DETAILS.

HISTORY &amp; PHYSICAL AND LIST OF MEDICATIONS MUST BE INCLUDED WITH THIS FAX.

FAX NUMBER: 1-800-413-3890/443-4585

TELEPHONE NUMBER: 1-800-219-7035/443-0320

Applicant's Name _____	SSN _____	Date of Birth _____
Diagnosis Primary _____	Physician _____	Phone No _____
Secondary _____	Nursing Facility _____	
Other _____	City _____	

Is there a current H & P ☐ Yes ☐ No If no, call Foundation for instructions.

- | A. | MENTAL ILLNESS  | YES                      | NO                       |
|----|---|--------------------------|--------------------------|
| 1. | Does the individual have a diagnosis of serious mental illness (MI)?<br>Diagnosis _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Does the individual have any indications of a mental illness? If yes, describe.<br>_____<br>_____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | If the applicant has a diagnosis or indications of mental illness, does the individual have a primary diagnosis of dementia?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Is the individual on antipsychotic medication? If yes, what is individual's a) current mental status; b) reason for medications; c) length of time on medications.<br>_____<br>_____<br>_____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Is individual on an antidepressant? If yes, indicate a) history of depression; b) length of depression; c) current depressive status; d) whether depression is situational due to circumstances.<br>_____<br>_____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | B. | MENTAL RETARDATION OR RELATED CONDITIONS   | YES                      | NO                       |
|----|--|--------------------------|--------------------------|
| 1. | Does the individual have a diagnoses of mental retardation (MR)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Does the individual have a diagnoses of a related condition (cerebral palsy, autism, seizures, etc.)? <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Has the individual ever been referred to or served by an agency/institution serving persons with mental retardation or related conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Does the individual have any indications of mental retardation or a related condition?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Does the individual have a traumatic brain injury?   | <input type="checkbox"/> | <input type="checkbox"/> |

**C. INFORMATION SOURCE**

The above information has been provided by: Name \_\_\_\_\_ Date \_\_\_\_\_  
Agency \_\_\_\_\_ Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**FOR FOUNDATION USE ONLY****D. REFERRAL FOR LEVEL II: MI MR** Referral made to: \_\_\_\_\_ Date \_\_\_\_\_**E. APPROVED** YES ☐ NO ☐

Comments: \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

## INSTRUCTIONS:

- A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment;

and as a result of the diagnosed mental condition, the applicant presently suffers from significant impairment in at least two of the following functional areas:

1. ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;
2. ability to maintain community living without dependence on public support systems and monitoring;
3. ability to develop and maintain personal relationships and support systems;
4. ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities;

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

- B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required by these persons. It is manifested before the person reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

- C. Self-explanatory.
- D. Do not fill out. For Foundation use only.
- E. Do not fill out. For Foundation use only.

## LEVEL OF CARE INSTRUCTIONS:

A Level of Care determination is required prior to Medicaid making payment to a nursing facility or the Home and Community Based Services Program (waiver). Any individual currently eligible, applying, or who intends to apply for Medicaid needs to request a determination. **Submit the MA-86 (Level of Care Determination) with at least identifying information via fax or telephone to the Foundation.** The Foundation will notify the applicant, referral source and county Office of Human Services of the results.

Department of Public Health  
and Human Services

SECTION:  
APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Waiting List Criteria Tool  
(DPHHS-SLTC-146) Instructions

**PURPOSE:** This tool was developed to assist Case Management Teams (CMT) in prioritizing each applicant's needs. The instrument is designed to complement professional judgment not replace it. Questions are geared toward assessing specific HCBS needs and to facilitate discussion.

**PROCEDURE:** It is left to the discretion of each CMT on how to use the tool. For example, some teams may choose to use just one form per applicant. Other teams may choose to have each team member fill out a separate form, combine the scores, and average the total scores. The minimum score is 14 and the maximum is 42. Use a range of scores when determining priorities. For example, rate those with scores between 14-22 as low, 23-30 as moderate, 31-38 as high and 39-42 as very high. Based on the scoring range and professional judgment, determine which individual in the highest range needs the services the most. Use the comment section to add information that will help in this decision.

**INSTRUCTIONS:** Level of Care--Mark the box describing the applicant's current level of care: care category 1, 2 or 3.

Applicant--Enter the applicant's name, date of birth, and county.

Care Category--Check the applicant's care category.

Review Dates--Enter date of each review.

1. Is applicant medically stable?--A score of one would reflect that the applicant is adequately maintaining medically at home. Two would reflect that some of the applicant's medical needs are being met, but additional services could help maintain or improve the applicant's



## SECTION:

## APPENDIX

## SUBJECT:

Waiting List Criteria Tool  
(DPHHS-SLTC-146) Instructions

medical status. A score of three would reflect a terminal or rapidly deteriorating condition, unmet skilled care needs or recent hospitalization or institutionalization.

2. Is applicant independently mobile?--A score of one means the person can ambulate without assistance or can maneuver a wheelchair without assistance. Two could reflect problems with independent ambulation such as frequent falls, need for cuing, or assistance with transfers. A score of three would be given to someone who is bed/chair confined or unable to ambulate or maneuver a wheelchair without assistance.
3. Is the applicant able to be alone for a period of 4-8 hours?--Score one for those who can be left alone without supervision. Score two if the applicant can be left alone at night, but needs assistance in the morning or vice-versa. Use three for those who cannot be left alone without supervision.
4. Does the applicant experience problems in judgment or have cognitive impairment?--A score of one would indicate the applicant is alert and oriented and is capable of making good decisions. Two would reflect that applicant is perhaps alert and oriented but uses poor judgment or has minor cognitive impairment (e.g., some short-term memory loss). A score of three would indicate consistent poor judgment or inability to function independently without supervision and/or constant reminders.
5. Is the applicant a former HCBS recipient?--A score of one indicates that the was not a former HCBS recipient. Two would indicate that the applicant was a former HCBS recipient but improved significantly and was discharged from HCBS. A score of three would indicate that the applicant was a former HCBS recipient

## SECTION:

## APPENDIX

## SUBJECT:

Waiting List Criteria Tool  
(DPHHS-SLTC-146) Instructions

and now resides in an institution or has had a medical crisis since discharge from HCBS.

6. Is applicant in an institution or at risk of institutionalization, deterioration, or death?--Score one if applicant is not in an institution or at risk of institutionalization, deterioration or death. Two would indicate that the applicant could be at risk without supportive services. A score of three could mean the applicant is at imminent risk of placement or death, the family situation will deteriorate without HCBS, or the applicant is in an institution.
7. Will the applicant live alone?--Score one if the applicant lives with a capable caregiver. Score two if the applicant lives alone and it is not a factor in determining safety. A score of two could also reflect that the applicant lives alone but has a relative or significant other who lives close by, or has someone who frequently (but not always) stays with the applicant. Two could also reflect that the recipient does not live alone, but the other person is unable or unwilling to meet all of the applicant's needs. Score three if the applicant will live alone.
8. Will the recipient live in adequate housing?--Score one if both the applicant and CMT perceive housing as adequate. Score two if there is a difference in opinion. For example, the applicant may think housing is adequate, but the CMT doesn't or vice-versa. Score three if both the applicant and CMT identify housing as inadequate.
9. Is there a need for adaptive aids or environmental modifications?--Score one if the recipient and CMT do not think adaptive aids or environmental modifications are necessary. Score two if there is a difference in opinion (the same as above question). Score three if



## SECTION:

## APPENDIX

## SUBJECT:

Waiting List Criteria Tool  
(DPHHS-SLTC-146) Instructions

the applicant and CMT both determine there are needs. Then assess for urgency of need.

10. Does the recipient need 24-hour supervision?-- Determine need for 24-hour availability of caregiver. Score one if the applicant does not need 24-hour supervision. Score two if the applicant needs 24-hour supervision but family or others are often available to provide care. Score three if applicant needs 24-hour supervision and caregivers need ongoing support.
11. Does caregiver need relief?--Score one if there is no caregiver or caregiver doesn't require relief. Score two if caregiver needs intermittent or occasional relief. Score three if caregiver requires immediate or ongoing relief.
12. Rate formal (paid) services.--Score one if services provided are adequate. Score two if the applicant is receiving services but needs additional community support. Score three if services are inadequate or funds are running low.
13. Rate informal (family/friends) support.--Score one if family or friends are able to provide adequate support. Score two if the applicant is receiving moderate support but could benefit from additional support to maintain or improve the situation. Score three if informal support is absent or inadequate.
14. Will the applicant's situation improve by receiving HCBS?--Score one if applicant will not accept services or will not benefit from HCBS services. Score two if minimal benefits are anticipated. Score three if maximum benefits are anticipated; i.e., CMT identifies needs and the applicant is receptive to HCBS.
15. Does the applicant need Waiver of Deeming to receive services?--Circle yes or no.

## SECTION:

APPENDIX

## SUBJECT:

Waiting List Criteria Tool  
(DPHHS-SLTC-146) Instructions

Total Score--Enter the total score obtained on the review date.

Comments--Use this section to include any information that is important for making determinations but is not necessarily addressed in the tool questions. For example, the applicant's current supportive services or specific service needs could be listed. This section can also be used to document status changes between review dates.

o o o

**HOME AND COMMUNITY BASED SERVICES  
WAITING LIST CRITERIA TOOL**Applicant: \_\_\_\_\_  
(Name) (Date of Birth) (County)Care Category: ☐ CC1/CC2 Nursing Facility ☐ CC3 Hospital

Review Dates: \_\_\_\_\_

1.	Is applicant medically stable?	Yes	1	2	No	3	1	2	3	1	2	3
2.	Is applicant independently mobile?	Yes	1	2	No	3	1	2	3	1	2	3
3.	Is applicant able to be alone for a period of 4-8 hours?	Yes	1	2	No	3	1	2	3	1	2	3
4.	Does applicant experience problems in judgment or have cognitive impairment?	Yes	3	2	No	1	3	2	1	3	2	1
5.	Is applicant a former HCBS applicant?	Yes	3	2	No	1	3	2	1	3	2	1
6.	Is applicant in an institution or at risk of institutionalization, deterioration or death?	Yes	3	2	No	1	3	2	1	3	2	1
7.	Will applicant live alone?	Yes	3	2	No	1	3	2	1	3	2	1
8.	Will applicant live in adequate housing?	Yes	1	2	No	3	1	2	3	1	2	3
9.	Is there a need for adaptive aids or environmental modifications?	Yes	3	2	No	1	3	2	1	3	2	
10.	Does applicant need 24-hour supervision?	Yes	3	2	No	1	3	2	1	3	2	1
11.	Does caregiver require relief?	Yes	3	2	No	1	3	2	1	3	2	1
12.	Rate formal (paid) services.	Good	1	2	Poor	3	1	2	3	1	2	3
13.	Rate informal (family/friends) support.	Good	1	2	Poor	3	1	2	3	1	2	3
14.	Will applicant's situation improve by receiving HCBS?	Yes	3	2	No	1	3	2	1	3	2	1
15.	Does applicant need Waiver of Deeming to receive services?	Yes			No							
TOTAL SCORE												

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Request for Prior Authorization  
for CC3 (DPHHS-MA-148)  
Instructions

**PURPOSE:** The Case Management Team (CMT) completes this form when requesting prior authorization for Care Category 3 (CC3) from Community Services Section.

**DISTRIBUTION:** The CMT sends the form to the Regional Program (RPO) for signature. After completing Section V, the RPO forwards the form to the Community Services Section for consideration. The Community Services Section keeps the pink copy and sends the white and yellow copies to the RPO. The RPO keeps yellow copy and forwards the white copy to the CMT.

**INSTRUCTIONS:** Recipient Information--The CMT lists the name of the recipient, Medicaid number, current living situation, provider number, and diagnosis. The current living situation would include information about where the recipient lives. For example, one bedroom apartment in name of apartment building, lives with mother, name of nursing facility, etc. If the recipient has another diagnosis other than one listed on the form, list the diagnosis.

Results If Not Accepted on HCBS--The CMT will check the appropriate category and list the projected cost of the facility. If the recipient is to remain in the community with family and support services, then CMT will list the support services being utilized and describe if these services adequately meet the needs of the recipient.

The CMT will describe the stress on the family or care giver for continuing to provide support and services to the recipient.

List any additional information that is pertinent to this request in the comment section.



## SECTION:

APPENDIX

## SUBJECT:

Request for Prior Authorization  
for CC3 (DPHHS-MA-148)  
Instructions

Home And Community Based Services Required--  
The CMT will describe how the recipient's  
needs can be met by HCBS and which services  
are required to meet these needs.

From the care plan and cost sheet, the CMT  
lists the projected cost.

Health Care Professional Involvement--The CMT  
will need to contact the health care profes-  
sional for their support in planning and  
delivering the HCBS services.

Regional Program Officer--The CMT forwards the  
request to the RPO for consideration. The RPO  
completes this section and forwards the form  
to the Community Services Section for consid-  
eration.

Community Services Section--Makes a decision  
on the request and forwards the white and  
yellow back to the RPO.

o o o

-



**HOME AND COMMUNITY BASED SERVICES  
REQUEST FOR PRIOR AUTHORIZATION FOR CC3  
(Ventilator Dependent, TBI-Bridges/Headway, Supported Living Clients)**

**RECIPIENT INFORMATION**

Name \_\_\_\_\_ Team Provider No. \_\_\_\_\_  
Medicaid # \_\_\_\_\_ Diagnosis: TBI \_\_\_\_\_ Vent. Dep. \_\_\_\_\_  
Current Living Situation: \_\_\_\_\_ Supported Living \_\_\_\_\_ Other: \_\_\_\_\_  
Explain: \_\_\_\_\_

**II. RESULTS IF NOT ACCEPTED ON HCBS**

\_\_\_\_\_ Remain in or enter hospital/rehab center. Projected cost: \_\_\_\_\_  
\_\_\_\_\_ Remain in or enter NF. Projected cost: \_\_\_\_\_  
\_\_\_\_\_ Remain in community or with family. What other support services are being utilized? Are these services adequate?  
\_\_\_\_\_  
Describe stress on family or caregiver: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOME AND COMMUNITY BASED SERVICES REQUIRED**

Explain how needs could be met by HCBS and what services would be utilized: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Anticipated Cost: \_\_\_\_\_

**IV. HEALTH CARE PROFESSIONAL INVOLVEMENT**

What is the extent of the health care professional involvement in the planning and delivery of services? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. REGIONAL PROGRAM OFFICER**

☐ Concur ☐ Do not concur  
\_\_\_\_\_  
Regional Program Officer \_\_\_\_\_ Date \_\_\_\_\_

**VI. COMMUNITY SERVICES SECTION**

☐ Concur ☐ Do not concur  
\_\_\_\_\_  
Community Services Section \_\_\_\_\_ Date \_\_\_\_\_



Department of Public Health  
and Human Services

SECTION:  
APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:  
Request for Prior Authorization  
(DPHHS-MA-149) Instructions

PURPOSE: The Case Management Team (CMT) completes this form when requesting a service that requires prior authorization as outlined in HCBS-410.

DISTRIBUTION: CMT retains pink copy as a suspense copy and forwards white and yellow copies to the Regional Program Officer (RPO). After completing Section V, the RPO will return the white copy to the CMT.

INSTRUCTIONS: Recipient Information--Enter name, county, and Medicaid number of the recipient. Check appropriate care category.

Type of Request--Enter cost for each category of services being requested. Cost sheet must be attached.

Narrative--Summarize justification for request.

Requester--Enter name and phone number of the CMT member filling out the form. Enter date of request.

Regional Program Officer--CMT forwards this request to the RPO for consideration. RPO will complete this section and return it to CMT.

o o o



Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Service Animals-Provider  
Assurances (DPHHS-MA-142)  
Instructions

PURPOSE:

This form must be signed by a potential provider of service animals as part of the provider enrollment process.

DISTRIBUTION:

Provider retains yellow copy and sends the white copy to the Department.

o o o



## HOME AND COMMUNITY BASED SERVICES PROGRAM SERVICE ANIMALS - PROVIDER ASSURANCES

The providers must sign off and make the following assurances to the State of Montana:

1. The provider will educate consumers on legal rights pertaining to service animals.
2. The provider will inform each prospective applicant of the organization's policy concerning return of the animal prior to any contractual agreement for reimbursement. Once reimbursement is made in full, the State of Montana will consider the service animal to be the legal possession of the consumer.
3. The provider will design a course of training for the consumer sufficient to master and maintain the Service Animal's performance of the skills as listed in the pre-training assessment until the service animal has reached the age of ten years. This would exclude the changing physical and cognitive needs of the handler as well as physical deterioration of the service animal.
4. All service animals provided by this agency will be spayed or neutered.
5. The service animal will meet minimum health and physical requirements to ensure it does not present a health risk to the public and is able to perform the tasks for which it is intended. The provider is responsible to ensure that the animal meets these requirements.
6. To the extent possible, a genetic background check will be performed and reviewed to ensure the animal is free from hereditary disease and/or problematic instincts. If this animal is a "shelter dog" then this wouldn't be expected, but any available information should be provided.
7. The animal will be screened for temperament and must be determined appropriate for the tasks it will be performing. At a minimum, this animal will not demonstrate inappropriate aggression toward people or other animals. The animal can not be excessively dominant, fearful, or submissive.<sup>1</sup>
8. As a condition of reimbursement; the provider will submit proof that the animal received and passed a basic physical exam given by a licensed and certified veterinarian that, at a minimum, includes:
  - a. Eyes - clear and disease free with normal function by an ACVA veterinarian.
  - b. Blood Panel - normal, parasite and disease free including heart worms.
  - c. Heart and Lungs - normal and disease free by a veterinary cardiologist.
  - d. Abdominal Organs - normal palpitation.
  - e. Skin and Coat - clean and free of disease (mange, dermatitis, allergies), ticks, fleas, other parasites, hot spots, and common ailments.
  - f. Skeletal/Muscles - normal structure for its breed, no deformities, i.e., hip dysplasia.
  - g. Stool - normal and free of parasites including worms and ova.
  - h. Immunizations and Vaccinations - appropriate for area of origin and the State of Montana including rabies, distemper, and parvo.
9. The provider will provide an appropriate collar and leash for each service animal. Other ancillary items and supplies necessary for the service animal to perform the consumer specific tasks may be negotiated on a case by case basis. This would also include itemized instructional materials.

---

(Signature)

---

(Title)

---

(Date)

<sup>1</sup> Some exceptions may be considered including "appropriate" dog/dog aggression or if the animal is in an extremely threatening situation. The important factor is that the behavior doesn't take away from the service animal's ability to preform the working behavior or service for the handler.

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Service Animals - Stewardship  
Agreement (DPHHS-MA-147)  
Instructions

PURPOSE:

This form must be signed by consumers for a service animal. By signing it, the consumers indicate their understanding and agreement to the responsibilities that are part of owning a service animal.

DISTRIBUTION:

The consumer retains the yellow copy and sends the white copy to the case management team.

o o o



## HOME AND COMMUNITY BASED SERVICES PROGRAM SERVICE ANIMALS - STEWARDSHIP AGREEMENT

**I understand:**

- I must be enrolled in the Home and Community Based Services program to be considered a candidate to receive Medicaid funding for the purpose of obtaining a service animal.
- The purpose of a service animal is to assist me to increase independence, decrease functional limitations, increase accessibility, and provide safety in the home and public environment.
- I must obtain a recommendation from a physician, occupational therapist, or a physical therapist stating that I will be able to benefit from the use of a service animal, detailing precisely how a service animal will assist me.
- I must actively participate in the selection of the approved service animal training organization to determine which one will be best able to meet my needs.
- I must actively participate in the training process in order to be able to competently work with the service animal. I will be required to successfully complete a DPHHS evaluation process to demonstrate proficiency in working with the service animal. The evaluation process includes an initial evaluation when the animal is placed and a follow-up evaluation approximately six months after placement.
- The training program and the service animal selected must be both the most adequate and cost effective intervention which can reasonable be expected to meet my needs.
- I am entering a working relationship with a service animal trained to meet my needs. I agree to meet the needs of the service animal and will provide care and companionship to that animal as long as I am able.
- I must select a veterinarian to provide medical care to the animal before I complete my service animal training period.

**I agree to the best of my ability to:**

- Provide a safe environment for the service animal to guard against injury or harm.
- Provide a healthy environment for the service animal including the provision of all food and nutritional needs and routine equipment such as water and food dish.
- Abide by all applicable leash and license laws.
- Assure the service animal is wearing identification and appropriate tags at all times.
- Maintain the service animal's basic obedience skills in public and at home.
- Assure the service animal receives regular and necessary health care and grooming.
- Assure the service animal is not abused at any time by anyone.
- Practice training with the service animal on a regular basis to maintain its working skills.
- Follow the training program's requirements for progress reports, follow-up training and medical reports.
- Make appropriate provisions for the service animal's stewardship by completing an action plan for emergencies or in the event that I am no longer able to provide care and companionship for the animal.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME AND COMMUNITY BASED  
SERVICES

SUBJECT:

Waiting List Database  
Instructions

Recipient Demographics--This is the screen on which you enter demographic data.

Date Demographic Record Created: The date you create the record

Date Demographics Last Update: The date you last updated the record. You may update a record because of a change in an individual's age, a change in current address, or a change in the type of slot the individual requires.

Team: Your team name.

Date of Referral: Date you received the referral from the Foundation.

Date of On-Site Visit: Date you visited individual to assess their need for services.

Client Information: Self explanatory.

Current Address Type: Where the individual is currently residing, i.e., in a nursing home, their own home, etc.

Alternate Address Type: This could be the individual's permanent address, the address of their guardian, or the address of a significant other.

Emergency contact, etc.: Self explanatory.

Health Issues: Name or description of health issues, i.e., COPD, TBI, etc.

Notes: Any notes you may want to include regarding the individual's condition.

## SECTION:

APPENDIX

## SUBJECT:

Waiting List Database  
Instructions**Services Recipient is Waiting For**

Date Placed on Waiting List: The date you placed individual on the waiting list.

Wait Score: The score the individual received on the Waiting List Tool (DPHHS-MA-146).

Year-End Money Candidate: Check this section if the individual could benefit from year-end money.

HCBS Services Needed: Check the type of slot the individual is waiting for.

Date Removed From Waiting List: Date individual was removed from the waiting list.

Disposition: Reason the individual was removed from the waiting list.

Status: Should be open if the individual is still waiting for a slot or closed if the individual is no longer waiting for a slot. If an individual is in a lower level slot (i.e., basic) or waiting for a higher level slot (i.e., adult residential), status should be marked 'open'.

Primary Reason Slot Needed: Describe the main reason individual needs slot, i.e., caregiver stress, risk of institutionalization, etc.

**Services or Support Currently Received**

Date Service Began: Date the services which the individual is currently receiving began. This can be the date individual was admitted to the nursing facility or the date state plan individual assistance services began.

Current Received Service or Support: Check the service(s) individual is currently receiving. Check Lower Level HCBS Services if the individual is in a lower level slot waiting for a higher level slot. For example, an individual may be in



## SECTION:

APPENDIX

## SUBJECT:

Waiting List Database  
Instructions

a basic slot waiting for an adult residential slot, or an individual may be in an adult residential slot waiting for a supported living slot, etc.

Notes: This section can be used for any comments you wish to make regarding the individual's situation.

o o o

Microsoft Access - [RECIPIENT DEMOGRAPHICS...]

File Edit View Insert Format Records Tools Window Help

11/18/98 11/18/98

Date Demographics Last Update 11/18/98

Date of Referral Date of On Site Visit:

Team:

Client Information...

Social Security Number: Birthdate: Disabled Elderly Child under 21

Male Female

First Name: Last Name:

Client Address Information...

Current Address Type... Address: City, State Zip: Select Country:> Phone Number:

Alternate Address Type... Address: City, State Zip: Select Country:> Phone Number:

Record: 1 of 1

Form View

Start Microsoft Access - [R... Microsoft Word - Document1]

8:42 AM



**Microsoft Access - [RECIPIENT DEMOGRAPHICS...]**

File Edit View Insert Format Records Tools Window Help

Emergency Contact Name  
Emergency Contact Phone  
Health Issues:  
Notes

Top of Page

Services Recipient is Waiting For  
Services Received for this Recipient  
Return to Switchboard

Record: 1 of 1  
Form View

Microsoft Access - [R...]  
Microsoft Word - Document1  
8:45 AM



Microsoft Access - [Services or Support Needed...]

File Edit View Insert Format Records Tools Window Help

# HCBS Waiting List Record...

Social Security Number:  Date Placed on WL: 02/02/1999  
 Wait Score:  0 ☐ Year End Money Candidate

**Disposition**  
☐ HCBS Slot Requested  
☒ HCBS Lower Level Slot  
☐ Nursing Facility  
☐ Hospital  
☐ Expired

**Date Removed from WL:**   
☐ No Longer Requires Services  
☐ No Longer Wants Services  
☐ Medicaid Ineligibility  
☐ Moved Out of State  
☐ Other

**HCBS Services Needed**  
☐ Basic  
☐ Adult Residential  
☐ Supported Living  
☐ Vent Dependent  
☐ Bridges/Headway

**Status**  
☒ Open  
☐ Closed

**Primary Reason Slot Needed:**

Record: 14 of 1 (Filtered)

Form View

**Micro** **File** **Form View** **Record** **Start**

**Services or Support Currently Received...**

Social Security Number:  Date Svc Began:  11/18/98  
End Date:

**Current Received Service or Support**

<input type="checkbox"/> Medicaid State Plan Services	<input type="checkbox"/> Foster Home
<input type="checkbox"/> Family/Friends	<input type="checkbox"/> Hospital
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Lower Level HCBS Services
<input type="checkbox"/> Personal Care Facility	

Notes:

Save Record Return to Recipient

Microsoft Access - [R...] Microsoft Word - Document1 8:46 AM





Department of Public Health  
and Human Services

## SECTION:

GLOSSARY

HOME AND COMMUNITY BASED  
SERVICES

## SUBJECT:

Definitions

A

ADMINISTRATIVE RULES OF MONTANA (ARM)--The rules by which all agencies of Montana State Government operate. Agency regulations, standards or statements of general applicability that implement, interpret or prescribe law or policy.

C

CASE MANAGEMENT--A process which coordinates multiple services for individuals through assessment, planning, arranging for and monitoring services.

CASE MANAGEMENT TEAM (CMT)--The agency that the Department contracts with to develop plans of care and manage and monitor the Home and Community Based Services Program on the local level.

COMMUNITY SERVICES BUREAU--The Bureau within the Department's Senior and Long Term Care Division which is responsible for administration of the Home and Community Based Services Program.

CONSULTEC--The organization that the Department contracts with to receive and process all Medicaid claims.

D

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)--The agency that is responsible for the administration of health and social service programs at the federal level.

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES (DPHHS)--The agency that is responsible for administering the Home and Community Based Services Program at the state level (hereinafter referred to as the Department).

## SECTION:

## GLOSSARY

## SUBJECT:

## Definitions

E

ELIGIBILITY STAFF--An employee located in the County Office of Human Services/Department of Public Welfare who is responsible for determining financial eligibility for Medicaid.

H

HEALTH CARE FINANCING ADMINISTRATION (HCFA)--The Division within the Department of Health and Human Services that is responsible for the operation of Medicare and the federal aspects of Medicaid, including the Home and Community Based Services Program.

HEALTH CARE PROFESSIONAL--The health care professional may be a M.D., nurse practitioner or physician assistant.

HOME AND COMMUNITY BASED SERVICES (HCBS)--Special Medicaid services designed to maintain an individual in the community who might otherwise require institutionalization for long-term care.

L

LEVEL OF CARE--A functional assessment used to determine if an individual requires the level of services normally provided in a skilled nursing facility.

LONG-TERM CARE FACILITY--Long-term care facilities include licensed skilled or intermediate nursing care, and intermediate care facility for the mentally retarded.

M

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)--The automated information system that includes information on all Medicaid providers, recipients and claims.

MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION (THE FOUNDATION)--The agency with which the Department contracts to complete level of care and Level I Screens.



## SECTION:

GLOSSARY

## SUBJECT:

Definitions

P

PLAN OF CARE--A written plan developed by the case management team and recipient to determine a recipient's needs and service selection.

PRIOR AUTHORIZATION--Prior approval granted by the Department to exceed service limits; and the system the Case Management Team uses to prior authorize services through Consultec.

R

RECIPIENT--An individual who has been approved for or receives Medicaid services.

REGIONAL PROGRAM OFFICER (RPO)--The DPHHS local Medicaid representative for Home and Community Based Services Section programs.

S

SCREENING--A medical, psychological and social evaluation of the individual to determine level of care. The screening is completed by the Mountain Pacific Quality Health Foundation.

T

TRAUMATIC BRAIN INJURY--An injury to the brain caused by an external physical force, including but not limited to a motor vehicle accident, a fall, an assault, a sports injury, or a recreational or work-related accident; or

Brain damage caused by internal occurrence including but not limited to:

A) disease, such as benign or malignant tumor, meningitis, or encephalitis; or

B) a cerebrovascular accident, such as stroke, atherosclerosis, aneurysm, or arteriovenous malformation; or

C) anoxia, including but not limited to anoxia caused by near drowning, drug overdose, kidney or heart failure, chemical exposure, or electrical shock.

## SECTION:

GLOSSARY

## SUBJECT:

Definitions

The term "traumatic brain injury" does not include injuries of degenerative or congenital nature.

Traumatic brain injury as defined may produce a diminished or altered state of consciousness that results in a temporary or permanent impairment of cognitive or mental abilities, physical functioning, or behavioral or emotional functioning.

o o o



Department of Public Health and Human Services	SECTION:  APPENDIX
HOME AND COMMUNITY BASED SERVICES	SUBJECT:  Abbreviations/Acronyms/ Initials

AAA	Area Agency on Aging
AFH	Adult Foster Home
AR	Adult Residential
ARM	Administrative Rules of Montana
CARF	Commission on Accreditation of Rehabilitation Facilities
CMT	Case Management Team
CSB	Community Services Bureau
DD	Developmentally Disabled
Department	Department of Public Health and Human Services (DPHHS)
DPHHS	Department of Public Health and Human Services
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HHS	Health and Human Services
ICF/MR	Intermediate Care Facility for the Mentally Retarded
MA	Medical Assistance
MCA	Montana Codes Annotated
MMIS	Medicaid Management Information System
NF	Nursing Facility
PA	Personal Assistant Prior Authorization

## SECTION:

APPENDIX

## SUBJECT:

Abbreviations/Acronyms/  
Initials

PAS	Personal Assistance Services
PCF	Personal Care Facility
QMRP	Qualified Mental Retardation Professional
RH	Residential Hospice
RPO	Regional Program Officer
SS	Social Services
SSA	Social Security Administration
SSI	Supplemental Security Income
STA	Specialized Trained Attendant
TBI	Traumatic Brain Injury
TPL	Third Party Liability
Title III	Older Americans Act
Title XVIII	Medicare
Title XIX	Medicaid
Title XX	Social Services
VR	Vocational Rehabilitation

o o o